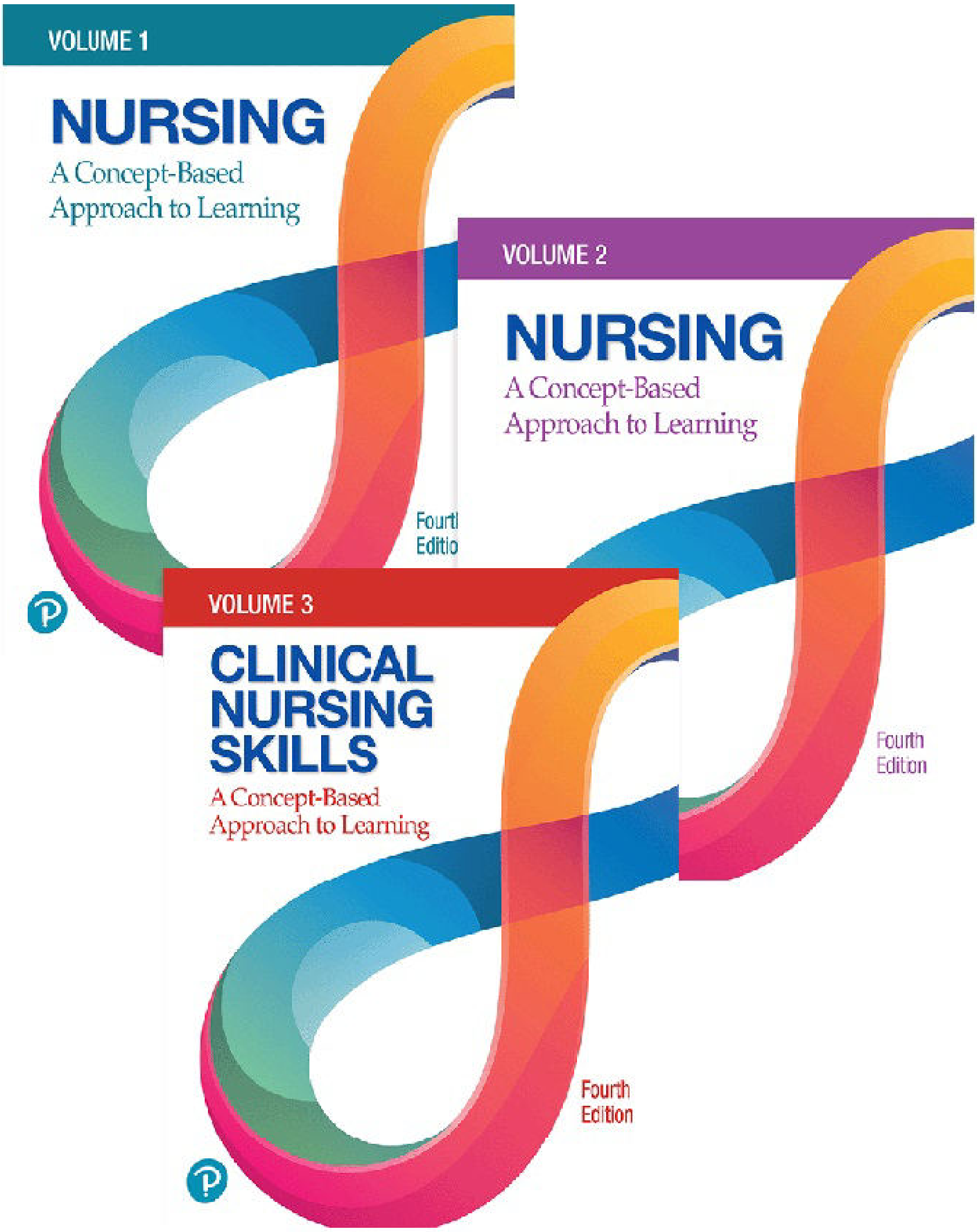
TEST BANK

Nursing: A Concept-Based Approach to Learning, Volume I, II & III

Pearson Education

4th Edition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NURSING
A Concept-Based Approach to Learning
Fourth Edition
VOLUME 2
NURSING
A Concept-Based Approach to Learning
Fourth Edition
VOLUME 3
CLINICAL NURSING SKILLS
A Concept-Based Approach to Learning
Fourth Edition

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Volume I and II

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)

Module 1 Acid-Base Balance

The Concept of Acid-Base Balance

1) A client who has been fasting and has ketones in the urine is brought to the emergency department (ED) unconscious. Which acid-base imbalance would the nurse expect to assess in this client?
A) Metabolic acidosis
B) Respiratory alkalosis
C) Metabolic alkalosis
D) Respiratory acidosis
Answer: A
Explanation: A) A client who is fasting is at risk for development of metabolic acidosis. The body recognizes fasting as starvation and begins to metabolize its own fatty acids into ketones, which are metabolic acids.
B) A client who is fasting is at risk for development of metabolic acidosis. The body recognizes fasting as starvation and begins to metabolize its own fatty acids into ketones, which are metabolic acids. Starvation would not result in respiratory alkalosis.
C) A client who is fasting is at risk for development of metabolic acidosis. The body recognizes fasting as starvation and begins to metabolize its own fatty acids into ketones, which are metabolic acids. Starvation would not result in metabolic alkalosis.
D) A client who is fasting is at risk for development of metabolic acidosis. The body recognizes fasting as starvation and begins to metabolize its own fatty acids into ketones, which are metabolic acids. Starvation would not result in respiratory acidosis.

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Page Ref: 5
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.2. Differentiate alterations in acid-base balance.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

2) The nurse is caring for a client in the emergency department. Which factors will the nurse identify that increase the client's risk for metabolic acidosis? **Select all that apply.**
A) Abdominal fistulas
B) Chronic obstructive pulmonary disease
C) Pneumonia
D) Chronic renal failure
E) Hypovolemic shock
Answer: A, D, E
Explanation: A) Metabolic acidosis is rarely a primary disorder. It usually develops during the course of another condition such as an abdominal fistula which can cause the loss of bicarbonate from the intestine.
B) Chronic obstructive pulmonary disease places the client at risk for respiratory acidosis with the increased retention of carbon dioxide in the blood.
C) Pneumonia places the client at risk for respiratory acidosis with the increased retention of carbon dioxide in the blood.
D) Metabolic acidosis is rarely a primary disorder. It usually develops during the course of another condition such as chronic renal failure. In this health problem, the kidneys are unable to excrete a normal amount of hydrogen ions in the urine. This results in an excessive amount of hydrogen ions in the blood, which produces metabolic acidosis.
E) Metabolic acidosis is rarely a primary disorder. It usually develops during the course of another condition such as hypovolemic shock. With a severe blood loss, there is a lack of blood flow throughout the body and a lack of oxygen in every cell. Adenosine triphosphate (ATP) must produce energy anaerobically without the presence of oxygen; lactic acid is a by-product. This produces systemic lactic acidosis, a type of metabolic acidosis.

Page Ref: 5-6
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.2. Differentiate alterations in acid-base balance.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

3) A client with acute asthma has a $PaCO_2$ of 48 mmHg, a pH of 7.31, and a normal HCO_3 arterial blood gas value. Which condition will the nurse associate with these values?
A) Metabolic acidosis
B) Respiratory alkalosis
C) Respiratory acidosis
D) Metabolic alkalosis
Answer: C
Explanation: A) Uncompensated metabolic acidosis has a decreased pH, normal $PaCO_2$, and decreased HCO_3.
B) Uncompensated respiratory alkalosis has an increased pH, decreased $PaCO_2$, and normal HCO_3.
C) If the pH is decreased and the $PaCO_2$ is increased with a normal HCO_3, it is uncompensated respiratory acidosis.
D) Uncompensated metabolic alkalosis has an increased pH, normal $PaCO_2$, and increased HCO_3.
Page Ref: 7
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Essential Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.2. Differentiate alterations in acid-base balance.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

4) The nurse is reviewing the latest arterial blood gas results for a client with metabolic alkalosis. Which result indicates that the metabolic alkalosis is compensated?

A) pH 7.32

B) $PaCO_2$ 18 mmHg

C) HCO_3 8 mEq/L

D) $PaCO_2$ 48 mmHg

Answer: D

Explanation: A) A normal pH level is 7.35-7.45. A pH of less than 7.35 is acidosis.

B) A $PaCO_2$ level of 18 mmHg is low and is seen in respiratory alkalosis.

C) A HCO_3 level of 8 mEq/L is low and is most likely associated with metabolic acidosis.

D) In metabolic alkalosis, there is an excess of bicarbonate. To compensate for this imbalance, the rate and depth of respirations decrease, leading to retention of carbon dioxide. The $PaCO_2$ will be elevated.

Page Ref: 8

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Essential Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 1.2. Differentiate alterations in acid-base balance.

MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

5) A client is diagnosed with chronic obstructive pulmonary disease. Which test provides the most accurate indicator of the client's acid-base balance?
A) Arterial blood gases (ABGs)
B) Pulse oximetry
C) Sputum studies
D) Bronchoscopy
Answer: A
Explanation: A) Acid-base balance is assessed primarily by measuring arterial blood gases (ABGs). Arterial blood is most often used because it reflects acid-base balance throughout the entire body better than venous or capillary blood that has dispersed oxygen into the tissues and has collected carbon dioxide.
B) Pulse oximetry is a noninvasive test that evaluates the oxygen saturation level of blood.
C) Sputum studies can provide specific information about bacterial organisms.
D) A bronchoscopy provides visualization of internal respiratory structures.
Page Ref: 10
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.5. Differentiate common assessment procedures and tests used to examine acid-base balance.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

6) The nurse is instructing a client with a history of acidosis on the use of sodium bicarbonate. Which client statement indicates that additional teaching is needed?
A) "I should contact the doctor if I have any gastric discomfort with chest pain."
B) "I need to purchase antacids without salt."
C) "I should use the antacid for at least 2 months."
D) "I should call the doctor if I get short of breath or start to sweat with this medication."
Answer: C
Explanation: A) The client should be instructed to immediately contact the primary healthcare provider if gastric discomfort occurs with chest pain.
B) The client should be instructed to use non-sodium antacids to prevent the absorption of excess sodium or bicarbonate into systemic circulation.
C) The client should be instructed to not use any bicarbonate antacid for longer than 2 weeks.
D) The client should be instructed to immediately contact the primary healthcare provider if dyspnea or diaphoresis occurs.
Page Ref: 6
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: patient/family/community preferences, values; coordination and integration of care; information, communication, and education; physical comfort and emotional support; involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 1.7. Summarize collaborative therapies used by interdisciplinary teams for clients with alterations in acid-base balance.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

7) A client is receiving sodium bicarbonate intravenously (IV) for correction of acidosis secondary to diabetic coma. The nurse assesses the client to be lethargic, confused, and breathing rapidly. Which action will the nurse take?

A) Stop the infusion and notify the physician because the client is in alkalosis.

B) Decrease the rate of the infusion and continue to assess the client for symptoms of alkalosis.

C) Continue the infusion, because the client is still in acidosis, and notify the healthcare provider.

D) Increase the rate of the infusion and continue to assess the client for symptoms of acidosis.

Answer: C

Explanation: A) The client's symptoms do not indicate alkalosis so infusion should not be stopped.

B) The client receiving sodium bicarbonate is prone to alkalosis; monitor for cyanosis, slow respirations, and irregular pulse.

C) The client continues to exhibit signs of acidosis; symptoms of acidosis include lethargy, confusion, CNS depression leading to coma, and a deep, rapid respiration rate that indicates an attempt by the lungs to rid the body of excess acid, and the physician should be notified.

D) The infusion should not be increased or decreased without a practitioner order.

Page Ref: 5-6

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

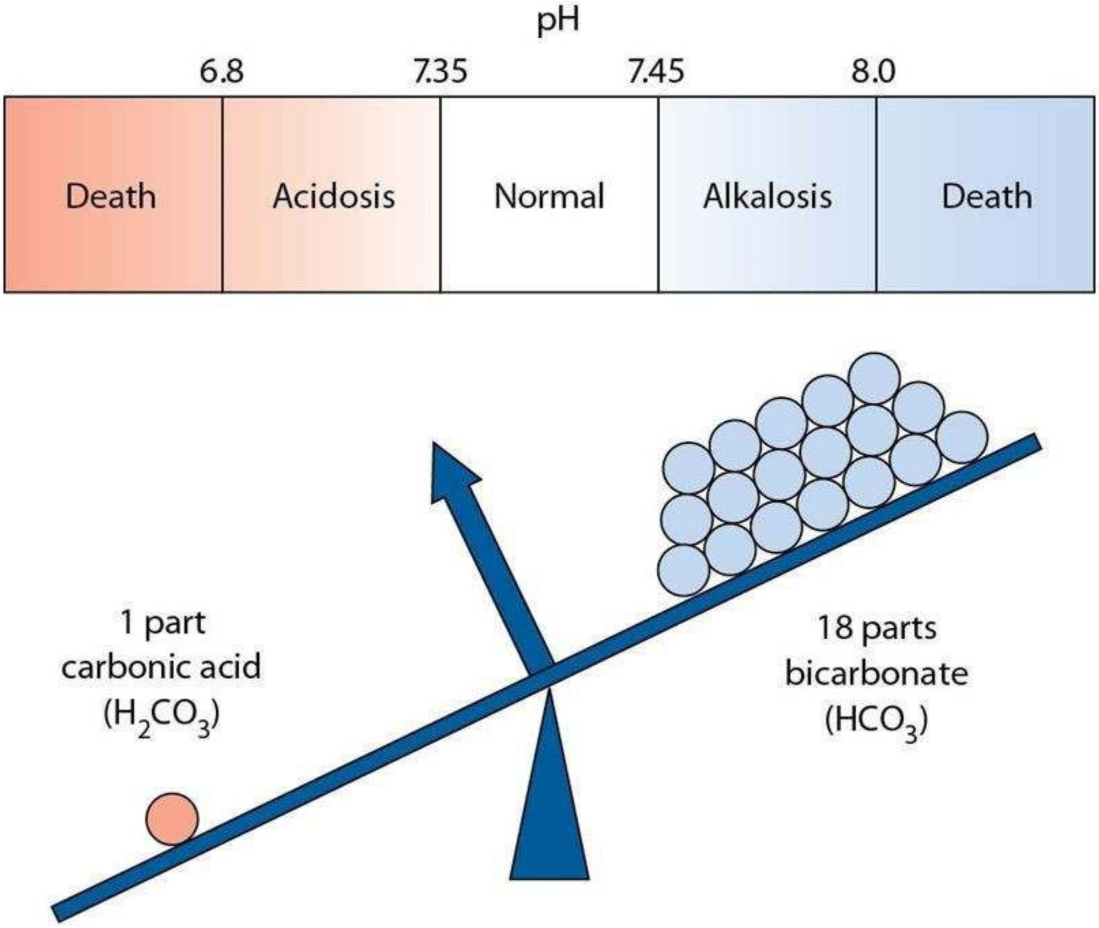
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 1.7. Summarize collaborative therapies used by interdisciplinary teams for clients with alterations in acid-base balance.

MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

8) The nurse is preparing to analyze an arterial blood gas to determine if a client has an acid-base imbalance. In which order will the nurse analyze this laboratory test?
1. Look at the $PaCO_2$.
2. Look at the pH.
3. Evaluate the relationship between pH and $PaCO_2$.
4. Look at the bicarbonate in relation to the pH.
Answer: 2, 1, 3, 4
Explanation: 1. The second step is to look at the $PaCO_2$. If the $PaCO_2$ is <40, then more carbon dioxide is being exhaled. If the $PaCO_2$ is >40, then more carbon dioxide is being retained.
2. The pH is the first step and is analyzed to determine if acidosis or alkalosis is present. A pH of <7.35 is acidosis. A pH of >7.45 is alkalosis.
3. The third step is to evaluate the relationship between the pH and the $PaCO_2$. This relationship could indicate a respiratory problem. If the pH is acidotic and the carbon dioxide level is greater than 40, then the client could be experiencing respiratory acidosis. If the pH is alkalotic and the carbon dioxide level is below 40, then the client could be experiencing respiratory alkalosis.
4. The fourth step is to look at the bicarbonate level in relation to the pH. If both the pH and bicarbonate level is decreased, then the client has metabolic acidosis. If the pH and bicarbonate levels are increased, the client has metabolic alkalosis.
Page Ref: 11
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.5. Differentiate common assessment procedures and tests used to examine acid-base balance.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

9) The nurse is identifying a diagram to use to explain a client's acid-base balance. Which imbalance does the diagram suggest is occurring with the client?


pH
6.8
7.35
7.45
8.0
Death
Acidosis
Normal
Alkalosis
Death
1 part
carbonic acid
(H_2CO_3)
18 parts
bicarbonate
(HCO_3)

A) Metabolic acidosis
B) Metabolic alkalosis
C) Respiratory acidosis
D) Respiratory alkalosis
Answer: A
Explanation: A) In metabolic acidosis, the amount of bicarbonate decreases in relation to the amount of acid in the body.
B) In metabolic alkalosis, there is an excess of bicarbonate in relation to the amount of hydrogen ions.
C) Respiratory acidosis occurs when carbon dioxide is retained, increasing the amount of carbonic acid in the body.
D) Respiratory alkalosis can occur when too much carbon dioxide is lost and carbonic acid levels fall.
Page Ref: 5
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.2. Differentiate alterations in acid-base balance.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

10) The results of a client's arterial blood gas sample reveal an oxygen level of 72 mmHg. For which associated health problem should the nurse assess this client?
A) Stress and coping
B) Perfusion
C) Fluid and electrolyte imbalance
D) Cognition
Answer: D
Explanation: A) Stress and coping may need to be analyzed to determine how the client is coping with the anxiety related to low oxygen levels, but this is not directly a physiological health problem.
B) Perfusion is affected by a reduction in circulating fluids.
C) With a fluid and electrolyte imbalance, there is another disorder affecting acid-base balance. This might not be affected by oxygen level.
D) An oxygen level of less than 75 mmHg can be due to hypoventilation. This drop in oxygen will change the client's level of responsiveness.
Page Ref: 10
Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.3. Outline the relationship between acid-base balance and other concepts.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

11) The nurse is caring for a comatose client with metabolic acidosis. For which intervention will the nurse need to collaborate when caring for this client?
A) Measuring vital signs
B) Measuring intake and output
C) The client's recent eating behaviors
D) Identifying current oxygen saturation level
Answer: C
Explanation: A) Measuring vital signs is an independent nursing action.
B) Measuring intake and output is an independent nursing action.
C) For clients in severe distress, family members may need to be consulted for critical information such as recent eating habits and history of vomiting.
D) Identifying current oxygen saturation level is an independent nursing action.
Page Ref: 12
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 1.7. Summarize collaborative therapies used by interdisciplinary teams for clients with alterations in acid-base balance.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

12) The nurse is beginning to review a client's arterial blood gas results. Which ion is measured to determine the pH?
A) Cl^-
B) H^+
C) Na^+
D) HCO_3
Answer: B
Explanation: A) Chloride (Cl^-) concentrations are not related to pH.
B) The pH measures the concentration of hydrogen ions (H^+) in the body.
C) Sodium (Na^+) concentrations are not related to pH.
D) Bicarbonate (HCO_3) is a weak base that is used as a buffer to help maintain the proper pH, but it is not used to measure pH.
Page Ref: 3
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.1. Analyze the physiology of normal acid-base balance.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

13) A client with a suspected acid-base imbalance has an arterial blood gases bicarbonate level of 18 mEq/L. In which way will the nurse interpret this result?
A) Slightly high
B) Slightly low
C) Extremely high
D) Within normal range
Answer: B
Explanation: A) The normal serum bicarbonate level is 22-26 mEq/L. A value of 18 mEq/L is not slightly high.
B) The normal serum bicarbonate level is 22-26 mEq/L. A value of 18 mEq/L is slightly low.
C) The normal serum bicarbonate level is 22-26 mEq/L. A value of 18 mEq/L is not extremely high.
D) The normal serum bicarbonate level is 22-26 mEq/L. A value of 18 mEq/L is not within the normal range.
Page Ref: 4
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.1. Analyze the physiology of normal acid-base balance.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

14) The nurse notes that a client's acid-base balance changes reflect hypoventilation or hyperventilation. On which concept will the nurse focus when planning care for this client?
A) Oxygenation
B) Perfusion
C) Cognition
D) Stress and coping
Answer: A
Explanation: A) Hypoventilation and hyperventilation are related to oxygenation. Respiratory rate helps regulate carbon dioxide pressures, which can contribute to acidosis or alkalosis.
B) Perfusion, does not directly relate to hypo- or hyperventilation.
C) Cognition does not directly relate to hypo- or hyperventilation.
D) Hypoventilation and hyperventilation are related to oxygenation. Respiratory rate helps regulate carbon dioxide pressures, which can contribute to acidosis or alkalosis. Stress and coping do not directly relate to hypo- or hyperventilation.
Page Ref: 10
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 1.3. Outline the relationship between acid-base balance and other concepts.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

15) The nurse is reviewing a client's acid-base balance. Which factor will the nurse prioritize as a health promotion activity?
A) Conducting yearly health screenings.
B) Obtaining immunizations.
C) Beginning an exercise regimen.
D) Maintaining fluid balance.
Answer: D
Explanation: A) Conducting yearly health screenings are activities that can promote health in other areas.
B) Obtaining immunizations is an activity that can promote health in other areas.
C) Beginning an exercise regimen is an activity that can promote health in other areas.
D) Both overhydration and dehydration can result in acid-base imbalances. Therefore, health promotion should focus on maintaining fluid balance.
Page Ref: 8
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.8 Promote self-care management. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 1.4. Explain the promotion of healthy acid-base balance.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

16) A client needs to have a sample of arterial blood for blood gas analysis. For which reason will the modified Allen test be performed before drawing the blood?
A) Reduce the risk of bleeding or bruising of the arm
B) Determine if arterial puncture can safely be performed
C) Determine the oxygen saturation of the blood in the artery
D) Determine the pressure of the blood in the artery
Answer: B
Explanation: A) The modified Allen test does not reduce the risk of bleeding or bruising.
B) A modified Allen test is a measure of ulnar patency. The client elevates the hand and repeatedly makes a fist while the examiner places digital occlusive pressure over the radial and ulnar arteries of the wrist. The hand will lose its normal color. Digital pressure is released from one artery while the other remains compressed. The return of color indicates that the hand has good collateral supply of blood and that arterial puncture can safely be performed.
C) The modified Allen test does not measure oxygen saturation.
D) The modified Allen test does not measure artery pressure.
Page Ref: 10
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 1.5. Differentiate common assessment procedures and tests used to examine acid-base balance.

MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

17) The nurse is caring for a client with an acid-base imbalance. Which intervention will the nurse complete independently?
A) Monitoring intake and output
B) Drawing blood for ABGs
C) Giving sodium bicarbonate infusions
D) Administering oxygen via nasal cannula
Answer: A
Explanation: A) Monitoring intake and output is an independent nursing intervention that does not require a provider's orders.
B) Drawing blood for ABGs is an action that can be performed by the nurse, but must first be ordered by a provider.
C) Giving sodium bicarbonate infusions can be performed by the nurse, but must first be ordered by a provider.
D) Administering oxygen via nasal cannula can be performed by the nurse, but must first be ordered by a provider.
Page Ref: 12
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.1. Describe own strengths, limitations, and values in functioning as a member of a team. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Scope of practice, roles, and responsibilities of healthcare team members, including overlaps. | Nursing Process: Implementation
Learning Outcome: 1.6. Analyze independent interventions nurses can implement for patients with alterations in acid-base balance.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

18) The nurse is caring for a client with acid-base imbalance. For which reason will the nurse measure the client's daily weight?
A) Monitor oxygenation status
B) Monitor perfusion of organs
C) Monitor renal function
D) Monitor fluid balance
Answer: D
Explanation: A) A client's weight does not reflect oxygenation status.
B) A client's weight does not reflect perfusion of organs.
C) Daily weights can reflect renal function, but weight can fluctuate even if the kidneys are functioning properly.
D) Fluid balance must be maintained to support acid-base balance. If a client rapidly gains weight, it is a sign of fluid overload. If a client rapidly loses weight, it is a sign of dehydration. Both of these conditions can alter the acid-base balance, so a client's weight should be monitored daily.
Page Ref: 8, 12
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.6. Analyze independent interventions nurses can implement for patients with alterations in acid-base balance.
MNL LO: Analyze the concept of acid-base balance and its application to nursing care.

Exemplar 1.A Metabolic Acidosis

1) A client recovering from cardiac arrest has an arterial blood gas pH of 6.58. Which explanation will the nurse suspect is the reason for this pH level?

A) Increased lactic acid level

B) Decreased carbohydrates for fuel

C) Decreased renal perfusion

D) Increased loss of bicarbonate

Answer: A

Explanation: A) Lactic acidosis is a common type of acidosis in hospitalized clients and develops with excess production or diminished excretion of lactic acid from the blood. Lactic acid is produced by anaerobic metabolism of glucose which occurs in cardiac arrest.

B) Lactic acid would increase in a client with diabetes when there is a lack of carbohydrates to be used for fuel.

C) The low pH that develops after a cardiac arrest is not due to decreased renal perfusion. The change in pH because of renal perfusion is due to an imbalance in bicarbonate level.

D) The low pH that occurs after a cardiac arrest is not caused by a loss of bicarbonate. Bicarbonate loss occurs in severe diarrhea and gastrointestinal disorders.

Page Ref: 14

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Describe the pathophysiology of metabolic acidosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

2) The nurse is caring for a client who has been admitted with persistent diarrhea lasting 3 days. Which problems will the nurse identify for this client during the acute phase of the illness?

Select all that apply.

A) Potential for decreased cardiac output
B) Problems clearing the airway
C) Inability to control urine output
D) Lack of information about the health problem
E) Risk for falls

Answer: A, E

Explanation: A) Metabolic acidosis decreases cardiac output by decreasing contractility, slowing the heart rate, and increasing the risk for dysrhythmias.
B) The client with metabolic acidosis will not have problems clearing the airway.
C) The client with metabolic acidosis will not have a problem with controlling urine output.
D) The client may have a lack of information about the health problem but this is not the priority during the acute phase of the illness.
E) The client with metabolic acidosis is at risk for injury from falls due to altered mental status.

Page Ref: 17

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Diagnosis

Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with metabolic acidosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

3) The nurse is caring for a client with metabolic acidosis. Which goals are appropriate for this client? **Select all that apply.**
A) The client will maintain a respiratory rate of 30 or more.
B) The client will describe preventative measures for the underlying chronic illness.
C) The client will maintain baseline cardiac rhythm.
D) The client will remain in a pH range from 7.25 to 7.35.
E) The client will take potassium supplements to increase potassium levels.
Answer: B, C
Explanation: A) The client's respiratory rate should be within normal range for age and condition.
B) Planning for the client with metabolic acidosis involves identification and treatment of the underlying cause and restoration and maintenance of acid-base balance. The client should be able to describe preventative measures for the underlying chronic illness that caused the metabolic acidosis to occur.
C) The client should be able to describe preventative measures to maintain the baseline cardiac rhythm.
D) The pH should be maintained between 7.35 and 7.45.
E) Taking a potassium supplement may cause hyperkalemia, which decreases cardiac output and worsens metabolic acidosis.
Page Ref: 17
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with metabolic acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

4) The nurse is caring for a client with renal failure and metabolic acidosis. Which clinical manifestation would indicate to the nurse that planned interventions to relieve the metabolic acidosis have been effective?

A) Decreased respiratory depth

B) Palpitations

C) Increased deep tendon reflexes

D) Respiratory rate of 38

Answer: A

Explanation: A) The client with metabolic acidosis will have an increased respiratory rate and depth, called Kussmaul respirations. Signs that care has been effective would include a decrease in the rate and depth of respirations.

B) Palpitations are not associated with metabolic acidosis.

C) Increased deep tendon reflexes are not associated with metabolic acidosis.

D) An increased respiratory rate, as indicated by a respiratory rate of 38, would indicate continued metabolic acidosis.

Page Ref: 15

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Identify the clinical manifestations of metabolic acidosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

5) The nurse is caring for a client with hypovolemic shock and metabolic acidosis. Which therapies would the nurse question if planned for this client? **Select all that apply.**
A) Monitor weight on admission and discharge
B) Monitor ECG for conduction problems
C) Limit the intake of fluids
D) Administer sodium bicarbonate
E) Keep the bed in the locked and low position
Answer: A, C
Explanation: A) Clients being treated for hypovolemia and metabolic acidosis will require daily weights, not a weight on admission and then discharge.
B) Monitoring ECGs are appropriate for the client with metabolic acidosis.
C) The treatment for hypovolemic shock would include the administration of fluids, not limiting fluids.
D) Administering sodium bicarbonate is appropriate for the client with metabolic acidosis.
E) The client recovering from hypovolemic shock and metabolic acidosis is at risk for injury, so the bed should be kept in the locked and low position.
Page Ref: 17-18
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with metabolic acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

6) A client with metabolic acidosis is experiencing confusion and weakness. Which nursing intervention is the priority for this client?
A) Placing the client in a high-Fowler position
B) Protecting the client from injury
C) Administering sodium bicarbonate
D) Providing the client with appropriate skin care
Answer: B
Explanation: A) The high-Fowler position would not be the safest position for the confused client.
B) The client with metabolic acidosis may have symptoms of drowsiness, lethargy, confusion, and weakness. A priority of care would be preventing injury to the client.
C) Medication administration is a physician order.
D) Skin care would not be a priority on admission.
Page Ref: 18
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with metabolic acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

7) The nurse is teaching a client with type 1 diabetes mellitus on the mechanism behind the development of ketoacidosis. List the order in which the nurse should provide this information.

1. Production of lactate and hydrogen ions
2. Tissue hypoxemia
3. Breakdown of fatty tissue
4. Reduction in intracellular glucose
5. Fatty acids converted to ketones

Answer: 2, 1, 4, 3, 5

Explanation: Lactic acidosis develops due to tissue hypoxia and a shift to anaerobic metabolism by the cells. Lactate and hydrogen ions are produced, forming lactic acid. Starvation or lack of insulin leads to intracellular starvation of glucose. The lack of glucose or insulin to move glucose into the cells causes the body to break down fatty tissue to meet metabolic needs. When fatty acids are broken down, these acids are converted to ketones, leading to the development of ketoacidosis.

Page Ref: 14

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Describe the pathophysiology of metabolic acidosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

8) A client with metabolic acidosis is at risk for an injury. Which strategies should the nurse use to prevent the client from experiencing an injury? **Select all that apply.**
A) Apply wrist restraints and secure to the bed frame.
B) Discuss chemical restraint use with the healthcare provider.
C) Keep the bed in the lowest position.
D) Keep upper bed side rails raised.
E) Place a clock and calendar at the bedside.
Answer: C, D, E
Explanation: A) Restraints are used in the event the client demonstrates harm to self or others.
B) A risk for injury is not a reason to use chemical restraints.
C) To reduce the client's risk for injury, the nurse should make sure the bed is kept in the lowest position.
D) To reduce the client's risk for injury, the nurse should make sure the upper side rails are raised. Raising all siderails is a form of restraint that cannot be done without a provider's order.
E) A clock and calendar at the bedside will help with orientation.
Page Ref: 18
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with metabolic acidosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

9) Upon entering a room, the nurse quickly scans the environment and then immediately assesses the client for manifestations of metabolic acidosis. Which observation caused the nurse to make this assessment?
A) Client sleeping with the head of the bed flat
B) Half of the client's lunch tray uneaten
C) One formed stool in the bedside commode
D) 2000 mL of intravenous 0.9% normal saline infused in 2 hours
Answer: D
Explanation: A) The head of the bed's being flat might influence a client's oxygenation status; however, the client was not demonstrating a change in respiratory depth or rate.
B) A reduction in oral intake does not cause metabolic acidosis. Eating half of a meal tray is not the same as starvation.
C) Diarrhea can lead to the development of metabolic acidosis. One formed stool would not cause the nurse alarm.
D) Excessive infusions of chloride-containing intravenous fluids can precipitate metabolic acidosis.
Page Ref: 15
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Compare the risk factors and prevention of metabolic acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

10) During a home visit, the nurse evaluates care provided to a client with type 1 diabetes mellitus and a history of metabolic acidosis. Which outcome indicates that the care of this client has been successful?

A) The client is injecting insulin into thigh muscle.

B) The client is taking laxatives three times a week to ensure adequate bowel movements.

C) The client is eating three balanced meals per day with two snacks.

D) The client is taking aspirin 325 mg every 6 hours to treat arthritis pain.

Answer: C

Explanation: A) Incorrect administration of medication could cause a metabolic problem in the client with diabetes.

B) The use of laxatives could cause diarrhea, which can lead to metabolic acidosis.

C) Adequate nutrition is necessary to prevent the buildup of acids in the blood.

D) Ingesting high amounts of salicylate acid can lead to toxicity and the development of metabolic acidosis.

Page Ref: 18

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care | Nursing Process: Evaluation

Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with metabolic acidosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

11) The nurse is preparing a teaching tool about metabolic acidosis. Which information will the nurse include that explains a common cause of this condition?
A) Hyperventilation in a client with anxiety
B) High blood glucose in a client with type 1 diabetes
C) Vomiting in a client with a gastrointestinal infection
D) Opiate overdose in a client with depression
Answer: B
Explanation: A) Hyperventilation can lead to respiratory alkalosis.
B) High blood glucose that leads to diabetic ketoacidosis is a common cause of metabolic acidosis.
C) Vomiting can lead to metabolic alkalosis.
D) Opiate overdose can lead to respiratory acidosis.
Page Ref: 15
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Describe the etiology of metabolic acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

12) The nurse is caring for a client with metabolic acidosis. Which assessment finding indicates to the nurse that the client is experiencing a compensatory mechanism to the disorder?
A) Headache
B) Kussmaul respirations
C) Vomiting
D) Decreased level of consciousness
Answer: B
Explanation: A) Headache is a clinical manifestation of metabolic acidosis, but is not a compensatory mechanism that the body uses to maintain acid-base balance during metabolic acidosis.
B) Kussmaul respirations are deep and rapid respirations that are a compensatory mechanism during metabolic acidosis.
C) Vomiting is a clinical manifestation of metabolic acidosis, but is not a compensatory mechanism that the body uses to maintain acid-base balance during metabolic acidosis.
D) Decreased level of consciousness is a clinical manifestation of metabolic acidosis, but is not a compensatory mechanism that the body uses to maintain acid-base balance during metabolic acidosis.
Page Ref: 15
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Identify the clinical manifestations of metabolic acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

13) The nurse is caring for a client with metabolic acidosis. Which medication will the nurse expect to be prescribed for this client?
A) Sodium bicarbonate
B) Sodium chloride
C) Potassium chloride
D) Dextrose
Answer: A
Explanation: A) Sodium bicarbonate is often given intravenously to clients with severe acute metabolic acidosis. It raises the pH of the blood.
B) Sodium chloride may worsen metabolic acidosis by increasing the chloride concentration.
C) Potassium chloride may worsen metabolic acidosis by increasing the chloride concentration.
D) Dextrose may worsen metabolic acidosis, especially in clients with type 1 diabetes, by increasing blood glucose levels and causing ketoacidosis.
Page Ref: 16
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Summarize diagnostic tests and therapies used by interdisciplinary teams in the collaborative care of an individual with metabolic acidosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

14) The nurse has been caring for a 3-month-old infant with fever, diarrhea, vomiting, and diaper rash over the past 48 hours. Which symptom puts this client most at risk for metabolic acidosis?
A) Fever
B) Diarrhea
C) Vomiting
D) Diaper rash
Answer: B
Explanation: A) Fever does not directly contribute to metabolic acidosis.
B) Infants are more susceptible to metabolic acidosis from diarrhea due to significant losses of bicarbonate in the feces.
C) Vomiting is more likely to result in metabolic alkalosis from loss of stomach acids.
D) Diaper rash does not directly contribute to metabolic acidosis.
Page Ref: 15
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Differentiate care of clients with metabolic acidosis across the lifespan.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

15) An older adult client has a history of heart disease and dementia and takes several medications. An accidental overdose of which medication could result in metabolic acidosis?
A) Losartan (an angiotensin II receptor blocker to reduce hypertension)
B) Simvastatin (a statin to reduce blood cholesterol levels)
C) Rivastigmine (a cholinesterase inhibitor to reduce symptoms of dementia)
D) Aspirin (a salicylate to decrease risk of heart attack)
Answer: D
Explanation: A) Acid-base balance is less affected by angiotensin II receptor blockers.
B) Acid-base balance is less affected by statins.
C) Acid-base balance is less affected by cholinesterase inhibitors.
D) Aspirin is salicylic acid, which could decrease the blood pH if taken in high quantities.
Page Ref: 15
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.4. Examine how the safety, quality and cost effectiveness of health care can be improved through the active involvement of patients and families. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment
Learning Outcome: 1.A. Analyze metabolic acidosis as it relates to acid-base balance. Differentiate care of clients with metabolic acidosis across the lifespan.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic acidosis.

Exemplar 1.B Metabolic Alkalosis

1) A client has been vomiting for several days. Which characteristic of gastric secretions increases the client's risk of developing metabolic alkalosis?
A) Gastric secretions are green in color.
B) Gastric secretions are alkaline.
C) Gastric secretions are acidic.
D) Gastric secretions have a foul smell.
Answer: C
Explanation: A) The color of gastric secretions has no influence on the development of metabolic acidosis.
B) Gastric secretions are not alkaline.
C) Metabolic alkalosis due to loss of hydrogen ions usually occurs because of vomiting or gastric suction. Gastric secretions are highly acidic (pH 1-3). When these are lost through vomiting or gastric suction, the alkalinity of body fluids increases. This increased alkalinity results from the loss of acid and from selective retention of bicarbonate by the kidneys as chloride is depleted.
D) The odor of gastric secretions has no influence on the development of metabolic acidosis.
Page Ref: 20
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Describe the pathophysiology of metabolic alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

2) The nurse is caring for a client with congestive heart failure. Which assessment data indicate that the client is at risk for metabolic alkalosis? **Select all that apply.**
A) Takes furosemide (Lasix) daily
B) Takes a baby aspirin once daily
C) Takes metformin daily
D) Uses calcium carbonate (Tums) for acid indigestion
E) Takes acetaminophen as needed for pain
Answer: A, D
Explanation: A) The use of a diuretic to remove excess fluid also increases the renal excretion of hydrogen ions, increasing the risk of alkalosis.
B) Overuse of aspirin can be associated with metabolic acidosis.
C) Use of metformin is not associated with alkalosis.
D) Excessive use of calcium carbonate can cause metabolic alkalosis.
E) Use of acetaminophen is not associated with metabolic alkalosis.
Page Ref: 20
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Describe the etiology of metabolic alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

3) An adolescent has been vomiting for several days because of food poisoning. Which information will the nurse include when teaching the parents about the illness? **Select all that apply.**
A) Immunizations for the adolescent
B) Nutritional patterns of the adolescent
C) Signs and symptoms of metabolic alkalosis
D) Proper food-handling techniques
E) Normal laboratory values of the adolescent
Answer: C, D
Explanation: A) Immunizations would not prevent the illness.
B) Food patterns of the adolescent are not the precipitating factor of the food poisoning.
C) The family of anyone experiencing prolonged vomiting should be taught the signs and symptoms of metabolic alkalosis.
D) The nurse would include teaching about proper methods of food handling to prevent further episodes of food poisoning.
E) It is not necessary to teach normal laboratory findings.
Page Ref: 21
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.8 Promote self-care management. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with metabolic alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

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4) The nurse is planning care for a client with metabolic alkalosis. Which problems will the nurse identify for this client? **Select all that apply.**

A) Nutritional deficits
B) Altered temperature regulation
C) Potential for fluid volume deficiency
D) Ineffective breathing pattern
E) Fall risk

Answer: B, C, D, E

Explanation: A) The reason for the metabolic alkalosis needs to be identified. Nutritional deficits may not be appropriate.
B) Clients with metabolic alkalosis often have accompanying disorders that would affect the temperature regulating mechanism.
C) Clients with metabolic alkalosis often have an accompanying deficiency in fluid volume.
D) Respiratory compensation for metabolic alkalosis includes depression of the respiratory rate and reduction of the depth of respirations, leading to the retention of carbon dioxide.
E) The client is at risk for injury because of the associated muscle spasms and dizziness.

Page Ref: 22
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Planning
Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with metabolic alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

5) A client with Cushing syndrome is experiencing complications from the condition. Which intervention should the nurse plan for this client to improve the impaired gas exchange?
A) Monitor serum electrolytes
B) Schedule nursing activities to allow for periods of rest
C) Assess input and output accurately
D) Administer IV fluids per provider's order
Answer: B
Explanation: A) Monitoring serum electrolytes would address an alteration in fluid volume.
B) The client with Cushing syndrome is at risk for developing severe metabolic alkalosis that causes hypoxemia and limits energy reserves. Spacing nursing activities throughout the day allows the client ample rest time.
C) Monitoring intake and output will address an alteration in fluid volume.
D) Intravenous fluids will address an alteration in fluid volume.
Page Ref: 23
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values.
AACN Essential Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with metabolic alkalosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

6) A client with heart failure is prescribed furosemide (Lasix). Which client statement indicates that teaching provided by the nurse was effective?
A) "I will use only sodium bicarbonate as my antacid."
B) "I will restrict my intake of fluids."
C) "I will use potassium supplements while I am taking Lasix."
D) "I will take antacids only for my gastric discomforts."
Answer: C
Explanation: A) The client should be instructed to refrain from the use of sodium antacids when prone to metabolic alkalosis.
B) The client who is prone to metabolic alkalosis is likely to have fluid deficits and would not be instructed to restrict fluids.
C) The client on furosemide (Lasix) may lose excess potassium, disposing the client toward metabolic alkalosis.
D) The client should consult with the primary care provider for gastric distress rather than self-medicate.
Page Ref: 21
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with metabolic alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

7) A client is diagnosed with severe metabolic alkalosis. Which action will the nurse prioritize for this client?
A) Administering medication for metabolic alkalosis
B) Monitoring oxygen saturation
C) Teaching the client the risk factors for metabolic alkalosis
D) Setting goals for the client with metabolic alkalosis
Answer: B
Explanation: A) Administering medications will be needed as a treatment, but the priority is to discover the cause.
B) The priority for this client is monitoring oxygen saturation. The depressed respiratory drive that often accompanies metabolic alkalosis can lead to hypoxemia and impaired oxygenation of the tissues.
C) Teaching the client is an important aspect of nursing care but is not the priority.
D) Setting goals is an important aspect of nursing care but is not the priority.
Page Ref: 22
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with metabolic alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

8) The nurse is caring for a client with hyperaldosteronism. In which position should this client be placed to enhance gas exchange?

A) Fowler position
B) Prone position
C) Left side-lying position
D) Right Sims position

Answer: A

Explanation: A) The client with hyperaldosteronism with metabolic alkalosis will likely have reduced oxygenation. The Fowler position will facilitate alveolar ventilation with improved oxygenation.

B) The prone position will not facilitate lung expansion.

C) Side-lying positions do not promote lung expansion.

D) Sims or a side-lying position will not promote lung expansion.

Page Ref: 23

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with metabolic alkalosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

9) The nurse notes that a client has a potassium level of 2.8 mEq/L and chloride level of 100 mEq/L. Which action will the nurse take?
A) Prepare to administer 0.9% sodium chloride infusion
B) Measure for nasogastric tube insertion
C) Notify the healthcare provider
D) Review the use of ammonium chloride
Answer: C
Explanation: A) Because the chloride level is within normal limits, an infusion of 0.9% sodium chloride is not indicated.
B) A nasogastric tube is not indicated for this client.
C) Because the client's potassium level is low, the healthcare provider should be notified.
D) There is not enough information to support the use of ammonium chloride for this client, as it is indicated to treat severe metabolic alkalosis.
Page Ref: 21
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Summarize diagnostic tests and therapies used by interdisciplinary teams in the collaborative care of an individual with metabolic alkalosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

10) A client with metabolic alkalosis is at risk for an ineffective breathing pattern. Which data did the nurse use to add this problem to the client's care plan? **Select all that apply.**
A) Respiratory rate 8 per minute
B) Oxygen saturation 89%
C) Urine output 25 mL/hr
D) Restlessness and agitation
E) Weight loss of 3 kg overnight
Answer: A, B, D
Explanation: A) Respiratory compensation for metabolic alkalosis depresses the respiratory rate and reduces the depth of breathing to promote carbon dioxide retention.
B) The depressed respiratory drive associated with metabolic alkalosis can lead to hypoxemia and impaired oxygenation of tissues. Oxygen saturation levels of less than 90% indicate significant oxygenation problems.
C) Urine output less than 30 mL/hr would indicate fluid volume deficit.
D) Changes in mental status or behavior may be early signs of hypoxia.
E) Weight is used as an indicator of fluid balance. A rapid weight change would indicate fluid volume deficit.
Page Ref: 22
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with metabolic alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

11) A client is experiencing symptoms of metabolic alkalosis. Which diagnostic test findings support the admitting diagnosis? **Select all that apply.**

A) Serum glucose level 142 mg/dL
B) Blood pH 7.47 and bicarbonate 34 mEq/L
C) Intravenous pyelogram shows kidney stones
D) Bilateral lower lobe infiltrates noted on chest x-ray
E) Electrocardiogram changes consistent with hypokalemia

Answer: B, E

Explanation: A) Serum glucose levels are not associated with metabolic alkalosis.
B) In metabolic alkalosis, the blood pH will be greater than 7.45 and the bicarbonate level greater than 26 mEq/L.
C) Kidney stones are not associated with metabolic alkalosis.
D) Lower lobe infiltrates are not associated with metabolic alkalosis.
E) The ECG pattern shows changes similar to those seen with hypokalemia.

Page Ref: 21

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Summarize diagnostic tests and therapies used by interdisciplinary teams in the collaborative care of an individual with metabolic alkalosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

12) During an assessment, the nurse becomes concerned that a client is at risk for developing metabolic alkalosis. Which finding caused the nurse to have this concern?
A) Daily ingestion of a banana with breakfast
B) Daily weight consistent
C) Daily use of sodium bicarbonate for gastric upset
D) Daily use of prescribed nonsteroidal anti-inflammatory drugs (NSAIDs) for arthritic pain
Answer: C
Explanation: A) Daily ingestion of a banana would prevent the development of hypokalemia from the daily use of sodium bicarbonate.
B) Consistent daily weights would indicate fluid balance.
C) Excess bicarbonate usually occurs as a result of ingesting antacids that contain bicarbonate, such as soda bicarbonate or Alka-Seltzer.
D) Daily use of NSAIDs would not support the development of metabolic alkalosis.
Page Ref: 21
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Compare the risk factors and prevention of metabolic alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

13) During a home visit, the nurse evaluates teaching provided to a client recovering from metabolic alkalosis. Which observation indicates that additional teaching is required?
A) Drinks 2 cups of black coffee each day
B) Consumes one orange each day with breakfast
C) Ingests bicarbonate of soda after each meal
D) Monitors and tracks daily weights
Answer: C
Explanation: A) Black coffee is not associated with the development of metabolic alkalosis.
B) Oranges contain potassium, which is beneficial to prevent the development of metabolic alkalosis.
C) The indiscriminate ingestion of sodium bicarbonate is a risk factor for the development of metabolic alkalosis.
D) Tracking of daily weights would help detect a fluid imbalance, which is associated with metabolic alkalosis.
Page Ref: 21
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Compare the risk factors and prevention of metabolic alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

14) The nurse is assessing a client with metabolic alkalosis. Which electrolyte imbalance will the nurse associate with the symptoms of this disorder?
A) Hypocalcemia
B) Hypokalemia
C) Hypercalcemia
D) Hyperkalemia
Answer: A
Explanation: A) Manifestations of metabolic alkalosis result from decreased calcium ionization and are similar to those of hypocalcemia. They include numbness and tingling around the mouth, fingers, and toes; dizziness; Trousseau sign; and muscle spasm.
B) Manifestations of metabolic alkalosis are not similar to those of hypokalemia.
C) Manifestations of metabolic are not similar to those of hypercalcemia.
D) Manifestations of metabolic alkalosis are not similar to those of hyperkalemia.
Page Ref: 21
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Identify the clinical manifestations of metabolic alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

15) A newborn with pyloric stenosis has symptoms of projectile vomiting, causing weight loss, dehydration, and metabolic alkalosis. What teaching is necessary for the parents in caring for the infant until surgery to correct the defect?

A) Monitoring for hyperventilation to detect changes in health status

B) Breastfeeding techniques to reverse weight loss and dehydration

C) Positioning of the infant to prevent aspiration

D) Performing percussion and postural drainage to clear the airways

Answer: C

Explanation: A) Hyperventilation leads to respiratory alkalosis and is usually unrelated to pyloric stenosis.

B) Because pyloric stenosis blocks passage of food from the stomach to the small intestines, increasing oral intake will not be beneficial to the infant, so breastfeeding techniques are irrelevant at this time.

C) Complications related to aspiration of vomitus can be prevented by correct positioning of the infant. Parents should be taught correct positioning so they can care for the infant at home or when the nurse is not available.

D) Percussion and postural drainage are more relevant to lung diseases such as cystic fibrosis, not a gastrointestinal (GI) disorder such as pyloric stenosis.

Page Ref: 22

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 1.B. Analyze metabolic alkalosis as it relates to acid-base balance. Differentiate care of clients with metabolic alkalosis across the lifespan.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

Exemplar 1.C Respiratory Acidosis

1) The nurse is caring for a client recovering from a morphine overdose. Which acid-base imbalance does the nurse expect to observe in this client?
A) Respiratory alkalosis
B) Respiratory acidosis
C) Metabolic alkalosis
D) Metabolic acidosis
Answer: B
Explanation: A) Respiratory alkalosis is caused by many conditions, none of which are related to this client's morphine overdose.
B) Morphine is a narcotic and generally acts to decrease or suppress respirations; therefore, this client is probably hypoventilating. The expected acid-base imbalance would be respiratory acidosis.
C) Metabolic alkalosis is caused by many conditions, none of which are related to this client's morphine overdose.
D) Metabolic acidosisis caused by many conditions, none of which are related to this client's morphine overdose.
Page Ref: 24
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Describe the pathophysiology of respiratory acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

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2) A client is diagnosed with respiratory failure and respiratory acidosis. Which data from the nursing history would the nurse suspect contributed to the client's current state of health?
A) Use of ibuprofen for the control of pain
B) A recent trip to South America
C) Aspiration pneumonia
D) Recent recovery from a cold virus
Answer: C
Explanation: A) Ibuprofen does not pose a threat to the respiratory health of the client.
B) A recent trip to South America would not constitute a respiratory risk factor.
C) Aspiration of a foreign body and acute pneumonia would put the client at risk for respiratory acidosis.
D) Recent recovery from a cold would not likely put the client at risk.
Page Ref: 25
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Compare the risk factors and prevention of respiratory acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

3) A school-age client is diagnosed with respiratory acidosis. Which chronic lung illness in the client's health history does the nurse suspect is causing the current diagnosis?
A) Cystic fibrosis
B) Aspiration
C) Hyperthyroidism
D) Pneumonia
Answer: A
Explanation: A) Chronic lung disease such as cystic fibrosis puts the child at risk for respiratory acidosis.
B) Aspiration is an acute lung condition.
C) Hyperthyroidism is a disorder that can cause metabolic acidosis.
D) Pneumonia is an acute lung condition.
Page Ref: 24-25
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice | NLN Competencies: Relationship Centered Care: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Describe the etiology of respiratory acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

4) A client with chronic obstructive pulmonary disease is diagnosed with respiratory acidosis. For which problem will the nurse plan care?
A) Inadequate gas exchange
B) Ineffective breathing pattern
C) Decreased cardiac output
D) Anxiety
Answer: A
Explanation: A) Inadequate gas exchange is the priority problem for the client with respiratory acidosis. Interventions are aimed at restoring effective alveolar ventilation and gas exchange.
B) There is no evidence that the client has an ineffective breathing pattern.
C) There is no evidence that the client has a change in cardiac output.
D) Although anxiety might occur, there is no evidence that the client is experiencing it.
Page Ref: 27
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory acidosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

5) An older adult is recovering from respiratory acidosis caused by restrictive lung disease and pneumonia. Which topics should the nurse include in the discharge teaching for this client?
Select all that apply.
A) Obtain annual influenza immunization
B) Engage in frequent hand washing
C) Avoid crowds
D) Cover the nose and mouth when coughing
E) Restrict fluids
Answer: A, B, C, D
Explanation: A) For the client with a history of chronic lung disease and pneumonia, the nurse should instruct on the importance of receiving annual influenza immunizations.
B) For the client with a history of chronic lung disease and pneumonia, the nurse should instruct on the importance of frequent hand washing.
C) For the client with a history of chronic lung disease and pneumonia, the nurse should instruct on the importance of avoiding crowds.
D) For the client with a history of chronic lung disease and pneumonia, the nurse should instruct on the importance of covering the nose and mouth when coughing.
E) Fluids should be encouraged to ensure that respiratory secretions are thin.
Page Ref: 27-28
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

6) The settings on mechanical ventilation for a client are: respiratory rate, 25 breaths per minute; tidal volume, 600 mL; FiO_2, 30%; humidification 30 mg H_2O/L. After being ventilated for 2 hours, arterial blood gas analysis reveals a pH of 7.20 and a $PaCO_2$ of 49 mmHg. Which change in ventilator settings should the nurse anticipate?
A) Increase in humidification of inspired air
B) Decrease of FiO_2 from 30% to 25%
C) Increased respiratory rate to 30 breaths per minute
D) Decreased tidal volume of each breath
Answer: C
Explanation: A) Humidification has no effect on the amount of CO_2 expelled.
B) Decreasing the FiO_2 would decrease the amount of CO_2 expelled.
C) This client is exhibiting respiratory acidosis that is not corrected by the current ventilator settings. This client needs to "blow off" more CO_2; therefore, the respiratory rate would be increased.
D) Decreasing the tidal volume would decrease the amount of CO_2 expelled.
Page Ref: 26
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise, and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Analysis

Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Summarize diagnostic tests and therapies used by interdisciplinary teams in the collaborative care of an individual with respiratory acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

7) A client with acute pneumonia is experiencing severe respiratory acidosis. Which treatments does the nurse anticipate as appropriate for this client? **Select all that apply.**
A) Administer oxygen prn
B) Administer digoxin for heart failure
C) Encourage up to 3 L of fluids per day
D) Place in a prone position
E) Reposition frequently
Answer: A, C, E

Explanation: A) The client with acute pneumonia and respiratory acidosis may require oxygen administration to improve gas exchange.

B) There is not enough evidence to know whether the client is experiencing heart failure as a result of the acute pneumonia.

C) The client with acute pneumonia and respiratory acidosis may increase fluid intake to thin secretions.

D) The client should be placed in the Fowler or semi-Fowler rather than the prone position.

E) The client with acute pneumonia and respiratory acidosis may require frequent repositioning to preventing the pooling of respiratory secretions.

Page Ref: 27

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory acidosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

8) The nurse is caring for a client recently extubated for treatment of aspiration pneumonia and respiratory acidosis. Which action by the nurse provides an optimum environment for this client?
A) Allowing family members to remain with client as much as possible
B) Restraining the client
C) Placing the client in a side-lying position
D) Administering narcotics for pain
Answer: A
Explanation: A) The client with respiratory acidosis often experiences anxiety. This client would benefit from having a family member in the room to provide reassurance.
B) Restraining the client will increase levels of agitation.
C) The client with respiratory failure would benefit most from the semi-Fowler or Fowler position to increase ventilation.
D) Narcotics will depress the respirations and increase respiratory acidosis. A nonnarcotic pain reliever would be considered if this client were experiencing pain.
Page Ref: 27
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.1 Engage with the individual in establishing a caring relationship. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

9) The nurse is reviewing prescriptions written for a client with chronic respiratory acidosis. Which prescription should the nurse question prior to implementation?
A) Keep head of the bed elevated to 40-degree angle.
B) Dextrose 5% and 0.45% normal saline at 100 mL per hour
C) Consult Respiratory Therapy for breathing treatments four times a day
D) Oxygen 6 liters per minute per nasal cannula
Answer: D
Explanation: A) Elevating the head of the bed promotes oxygenation.
B) Adequate hydration such as intravenous fluids is important to promote removal of respiratory secretions.
C) Pulmonary hygiene measures such as breathing treatments may be instituted.
D) In clients with chronic respiratory acidosis, oxygen is administered cautiously to prevent carbon dioxide narcosis.
Page Ref: 27
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory acidosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

10) A client with pneumonia develops respiratory acidosis. Which medications should the nurse anticipate for this client? **Select all that apply.**
A) The loop diuretic furosemide (Lasix), 20 mg by mouth twice a day
B) The antibiotic amoxicillin, 1 gram intravenous every 6 hours
C) The bronchodilator albuterol, inhaler 2 puffs every 4 hours
D) The anxiolytic diazepam (Valium), 2 mg by mouth at bedtime for sleep
E) Potassium chloride 20 mEq in 100 mL 0.9% normal saline intravenous every day
Answer: B, C
Explanation: A) Diuretics are not used to treat this disorder.
B) Antibiotics such as amoxicillin may be prescribed to treat respiratory infections.
C) Bronchodilator drugs such as an albuterol inhaler may be administered to open the airways.
D) Benzodiazepines such as diazepam are central nervous system depressants and would adversely affect this client's respiratory rate, adversely affecting respiratory acidosis.
E) Potassium chloride is indicated in the treatment of metabolic alkalosis.
Page Ref: 26
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Summarize diagnostic tests and therapies used by interdisciplinary teams in the collaborative care of an individual with respiratory acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

11) A client being treated for an overdose is in acute respiratory acidosis. Which substance found on the toxicology analysis is most likely the cause for the client's current condition?
A) Cocaine
B) Marijuana
C) Oxycodone
D) PCP
Answer: C
Explanation: A) Cocaine is a stimulant.
B) Marijuana does not depress the central nervous system or respiratory center.
C) Oxycodone is an opiate narcotic. Excessive use or overdose of narcotic substances can lead to respiratory depression and respiratory acidosis.
D) PCP is a hallucinogenic agent.
Page Ref: 26
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Describe the etiology of respiratory acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

12) The nurse suspects a client with one functioning lung is developing chronic respiratory acidosis. Which manifestation did the nurse assess in this client?
A) Warm, flushed skin
B) Daytime sleepiness
C) Irritability
D) Blurred vision
Answer: B
Explanation: A) The client with acute respiratory acidosis may demonstrate warm, flushed skin.
B) The manifestations of acute and chronic respiratory acidosis differ. The client with chronic respiratory acidosis will demonstrate daytime sleepiness.
C) The client with acute respiratory acidosis may demonstrate irritability.
D) The client with acute respiratory acidosis may demonstrate blurred vision from the acute decline in oxygenation.
Page Ref: 25
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Identify the clinical manifestations of respiratory acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

13) The nurse instructs a client with a history of acute respiratory acidosis and lung infections on ways to prevent further episodes of the health problem. Which client statement indicates that teaching has been effective?
A) "I will limit drinking alcohol to the evening hours only."
B) "I will limit my intake of bananas and oranges."
C) "I will take prescribed antibiotics until my symptoms subside."
D) "I will receive the annual influenza vaccination."
Answer: D
Explanation: A) Alcohol is a central nervous system depressant, which can adversely affect respiratory status and lead to the development of respiratory acidosis.
B) The ingestion of bananas and oranges will not promote the development of respiratory acidosis.
C) The client should be instructed to complete a full course of antibiotics prescribed to treat infections.
D) The nurse should discuss ways to avoid future episodes of acute respiratory infections by encouraging the client to receive immunization against pneumococcal pneumonia and influenza.
Page Ref: 27
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

14) The nurse is planning care for an older client with respiratory acidosis. Which intervention should the nurse include in this client's plan of care?
A) Administer prescribed intravenous fluids carefully.
B) Administer intravenous sodium bicarbonate.
C) Maintain adequate hydration.
D) Reduce environmental stimuli.
Answer: C
Explanation: A) Careful administration of intravenous fluids is important in the older client with metabolic alkalosis because older clients are at risk because of their fragile fluid and electrolyte status.
B) Sodium bicarbonate is indicated in the treatment of metabolic acidosis.
C) In respiratory acidosis, there is a drop in the blood pH, a reduced level of oxygen, and retention of carbon dioxide. The body needs to be well-hydrated so that pulmonary secretions can be removed to improve oxygenation.
D) Reducing environmental stimuli would be appropriate for the client with respiratory alkalosis.
Page Ref: 26
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

15) The nurse is caring for a client with acute respiratory acidosis. Which effect from this disorder can lead to changes in the neurologic and cardiovascular systems?
A) Hypercapnia
B) Carbon dioxide narcosis
C) Hypoventilation
D) Hyperventilation
Answer: A
Explanation: A) In acute respiratory acidosis, increased carbon dioxide levels, also called hypercapnia, can affect neurological function and the cardiovascular system.
B) Carbon dioxide narcosis occurs in chronic respiratory acidosis.
C) Hypoventilation causes respiratory acidosis; it doesn't result from respiratory acidosis.
D) Hyperventilation is related to respiratory alkalosis, not respiratory acidosis.
Page Ref: 24
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Describe the pathophysiology of respiratory acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

16) A client with respiratory acidosis is demonstrating signs of neurologic changes. In which way will hypercapnia affect this client?
A) Decrease pulse rate
B) Cause hyperventilation
C) Cause cerebral vasodilation
D) Lead to neurotransmitter disturbances
Answer: C
Explanation: A) The pulse rate is elevated in acute respiratory acidosis, not decreased.
B) Respiratory acidosis is caused by hypoventilation, not hyperventilation.
C) Hypercapnia causes cerebral vasodilation, which results in headache, blurred vision, irritability, mental cloudiness, and decreased level of consciousness.
D) Neurotransmitter disturbances are unrelated to respiratory acidosis.
Page Ref: 25
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.C. Analyze respiratory acidosis as it relates to acid-base balance. Identify the clinical manifestations of respiratory acidosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with respiratory acidosis.

Exemplar 1.D Respiratory Alkalosis

1) A client in severe pain is diagnosed with respiratory alkalosis. Which arterial blood gas value does the nurse document to support this diagnosis?

A) pH is 7.33 and $PaCO_2$ is 36.
B) pH is 7.51 and HCO_3 is 30.
C) pH is 7.47 and $PaCO_2$ is 25.
D) pH is 7.35 and PaO_2 is 88.
Answer: C
Explanation: A) The pH would denote alkalosis and would be higher than 7.45.
B) HCO_3 would trend downward as the kidneys begin to compensate for the alkalosis by excreting HCO_3.
C) Acute pain usually causes hyperventilation, which causes the $PaCO_2$ to drop and the client to experience respiratory alkalosis. The pH would denote alkalosis and would be higher than 7.45.
D) The pH would denote alkalosis and would be higher than 7.45.
Page Ref: 29
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 1.D. Analyze respiratory alkalosis as it relates to acid-base balance. Describe the pathophysiology of respiratory alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

2) The client seeks medical attention for symptoms of a panic attack, including hyperventilation. For which health problem will the nurse plan care for the client?
A) Hypoventilation
B) Vomiting
C) Respiratory alkalosis
D) Memory loss
Answer: C
Explanation: A) Anxiety and panic attacks will lead to hyperventilation, not hypoventilation.
B) The client with anxiety does not necessarily have vomiting as a risk factor.
C) Anxiety disorders increase the risk for the acid-base imbalance respiratory alkalosis, due to hyperventilation that accompanies anxiety and panic attacks.
D) The client with anxiety does not necessarily have memory loss.
Page Ref: 29
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 1.C. Analyze respiratory alkalosis as it relates to acid-base balance. Describe the etiology of respiratory alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

3) The nurse is caring for an older adult who is hyperventilating. Which statement will the nurse make when helping the client slow the breathing?
A) "What are you afraid of?"
B) "Slow down your breathing."
C) "Why are you breathing so fast?"
D) "Watch me and we can breathe together."
Answer: D
Explanation: A) Statements should be used instead of asking direct questions.
B) Telling the client to slow breathing without demonstrating it will not be effective.
C) The client may not know why the breathing is rapid.
D) Clients who are hyperventilating will be frightened and anxious. Helping them to slow down their breathing will help to resolve respiratory alkalosis. Use a calm voice and exhibit an even demeanor. Reassure clients that helping them to breathe more slowly will make them feel better. Since communication may be difficult, use statements such as "watch me and we can breathe together."
Page Ref: 30
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.8 Promote self-care management | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 1.D. Analyze respiratory alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

4) A client is diagnosed with a salicylate overdose. Which problem will the nurse prioritize for this client?
A) Ineffective breathing pattern
B) Powerlessness
C) Potential for injury
D) Impaired mobility
Answer: A
Explanation: A) The client with a salicylate overdose is at risk for hyperventilation, which can lead to respiratory alkalosis.
B) There is not enough evidence to determine if powerlessness is a priority for this client.
C) Potential for injury might be an issue if breathing is not addressed.
D) There is not enough information to know whether the client's mobility is impaired.
Page Ref: 31
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 1.D. Analyze respiratory alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

5) A client with an anxiety disorder is being discharged. Which teaching will the nurse prepare for this client? **Select all that apply.**

A) Refer the client for counseling
B) Instruct the client to eat foods high in acid
C) Teach the client the signs of impending panic attack
D) Advise the client to breathe into a paper bag when feeling anxious
E) Instruct the client to breathe slowly

Answer: A, C, E

Explanation: A) The client with an anxiety disorder should be referred to counseling to assist with management of the disorder.
B) Eating foods high in acid will not counteract the results of hyperventilation.
C) The client with an anxiety disorder should be taught signs of an impending panic attack.
D) The use of paper bags has been a recommended treatment for hyperventilation; however, it can also cause hypoxia.
E) Teaching the client to breathe slowly helps the client manage hyperventilation at home.

Page Ref: 30
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.8 Promote self-care management. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 1.D. Analyze respiratory alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

6) The nurse instructs a client with an anxiety disorder. Which client statement indicates that client teaching about respiratory alkalosis has been effective?
A) "I will see my counselor on a regular basis."
B) "I will breathe faster when I am feeling anxious."
C) "I will eat more bananas at breakfast."
D) "I will not take antacids when I have heartburn."
Answer: A
Explanation: A) The client understands that reducing anxiety can reduce hyperventilation and respiratory alkalosis. Seeing a counselor can help the client develop alternative strategies for dealing with anxiety.
B) Breathing faster will increase hyperventilation.
C) Eating bananas is more appropriate for the client at risk for metabolic alkalosis who is on diuretics.
D) Taking too many antacids is associated with metabolic alkalosis.
Page Ref: 31
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 1.D. Analyze respiratory alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

7) A client is diagnosed with respiratory alkalosis. Which prescriptions would be appropriate for this client's care needs? **Select all that apply.**
A) Oxygen 2 liters via face mask
B) Restrict fluids to 2 liters per day
C) Admit to a private room
D) Infuse 1 ampule of sodium bicarbonate now
E) Draw arterial blood gases
Answer: C, E
Explanation: A) The client has respiratory alkalosis, which is caused by hyperventilation. Additional oxygen is not required.
B) A fluid restriction is not required in the treatment of respiratory alkalosis.
C) It is important to create a calm, quiet, low-stimulation environment to reduce the client's anxiety or panic.
D) Sodium bicarbonate is used in the treatment of respiratory and metabolic acidosis.
E) Arterial blood gases must be ordered prior to beginning medication or oxygen therapy.
Page Ref: 29
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 1.D. Analyze respiratory alkalosis as it relates to acid-base balance. Summarize diagnostic tests and therapies used by interdisciplinary teams in the collaborative care of an individual with respiratory alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

8) A client with a history of anxiety is experiencing chest pain, palpitations, and dyspnea. Which intervention would be a priority for this client?
A) Providing educational material for the client's medical diagnosis
B) Ordering a regular diet for the client
C) Reassuring the client that symptoms will resolve
D) Asking Respiratory Therapy to set up a mechanical ventilator
Answer: C
Explanation: A) Providing teaching for the client becomes a priority when the client is recovering from the illness.
B) Ordering the diet is done by the healthcare provider.
C) The client will require reassurance from the nurse that the symptoms being experienced are not those of a heart attack and that the symptoms will resolve when the breathing pattern returns to normal.
D) Instructing the respiratory therapist is done by the healthcare provider.
Page Ref: 31
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 1.D. Analyze respiratory alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

9) A client with metabolic alkalosis is experiencing numbness around the mouth and tingling of the fingers. Which information will the nurse provide as the reason for these manifestations?

A) "Because you are breathing so fast, the oxygen is not getting to your nerve endings."

B) "Your health problem affects calcium in your body, which causes the tingling around your mouth and fingers."

C) "You have a buildup of carbon dioxide in your blood."

D) "You don't have enough potassium in your body, so the tingling around your mouth and fingers will occur."

Answer: B

Explanation: A) Rapid breathing is not reducing the amount of oxygen reaching the nerve endings.

B) Alkalosis increases binding of extracellular calcium to albumin, reducing ionized calcium levels. As a result, neuromuscular excitability increases, and manifestations similar to hypocalcemia develop. These manifestations include circumoral and distal extremity paresthesias.

C) Excessive carbon dioxide would lead to acidosis.

D) Respiratory alkalosis is not caused by an imbalance of serum potassium.

Page Ref: 29

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 1.D. Analyze respiratory alkalosis as it relates to acid-base balance. Identify the clinical manifestations of respiratory alkalosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

10) A client who is intubated is fighting the ventilator and attempting to pull out the endotracheal tube. Which action will the nurse take to reduce this client's risk of developing respiratory alkalosis?
A) Administer a sedative as prescribed
B) Apply wrist restraints
C) Teach the client to take slow, deep breaths
D) Discuss removing the endotracheal tube with the healthcare provider
Answer: A
Explanation: A) For a client being mechanically ventilated, the only way to reduce rapid respirations might be to provide a sedative.
B) Applying wrist restraints to a client who is demonstrating anxiety with an endotracheal tube might increase the client's anxiety.
C) The client is being mechanically ventilated, which means there is a problem with maintaining the airway. The client will not be able to take slow, deep breaths at this time.
D) The reason for the endotracheal tube is to maintain the client's airway. Removing the tube could lead to a collapse of the airway and a life-threatening situation.
Page Ref: 29
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 1.D. Analyze respiratory alkalosis as it relates to acid-base balance. Summarize diagnostic tests and therapies used by interdisciplinary teams in the collaborative care of an individual with respiratory alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

11) The nurse is evaluating care provided to a client with respiratory alkalosis. Which outcomes indicate that nursing care has been effective for this client? **Select all that apply.**

A) Respiratory rate 18 and regular

B) Sleeping through the night

C) Gait steady

D) Consistent body weight

E) Using prescribed bronchodilators

Answer: A, B, C, D

Explanation: A) Appropriate outcomes for the care of a client with respiratory alkalosis include normal respiratory rate and rhythm.

B) Ability to sleep through the night would indicate a reduction in anxiety, which is a risk factor for the development of respiratory alkalosis.

C) Appropriate outcomes for the care of a client with respiratory alkalosis include no episodes of injuries.

D) Appropriate outcomes for the care of a client with respiratory alkalosis include maintenance of fluid balance.

E) Bronchodilators are not used to treat this acid-base imbalance.

Page Ref: 31

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 1.D. Analyze respiratory alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory alkalosis.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

12) A client is brought to the emergency department (ED) with rapid breathing after learning of a family member being killed in a house fire. Which action will the nurse complete first to help this client?
A) Coach to slow the breathing
B) Move to a quiet, calm environment
C) Provide a sedative
D) Ask for a psychiatric consultation
Answer: B
Explanation: A) Once the environment is controlled, the nurse can begin to implement interventions to help the client slow the breathing rate.
B) Nursing care is focused on reducing anxiety through manipulation of the environment to reduce stimuli and to create a sense of peace. This restful environment will help the client breathe more slowly and effectively.
C) A sedative may be prescribed; however, this would not be the first intervention.
D) A psychiatric consult might be indicated for someone with a history of anxiety or panic attacks that lead to the development of respiratory alkalosis. Because this client has had a shock, a psychiatric consultation would not be indicated at this time.
Page Ref: 31
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 1.D. Analyze respiratory alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

13) A client begins to hyperventilate after learning that a breast biopsy was positive for cancer. After a few minutes, the client loses consciousness. Which action by the nurse is the priority?
A) Begin cardiopulmonary resuscitation
B) Raise the side rails on the bed
C) Notify the physician
D) Insert an intravenous access device
Answer: B
Explanation: A) The client does not need cardiopulmonary resuscitation.
B) The nurse should protect the client from injury. If hyperventilation continues to the point where the client loses consciousness, respirations will return to normal, as will acid-base balance.
C) The physician may need to be notified; however, the client's safety is a priority.
D) The client is not critically ill, and an intravenous access device is not indicated at this time.
Page Ref: 31
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 1.D. Analyze respiratory alkalosis as it relates to acid-base balance. Apply the nursing process in providing culturally competent care to an individual with respiratory alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

14) The nurse is preparing a teaching tool about respiratory alkalosis. Which disorder will the nurse identify that increases the risk for this acid-base imbalance?
A) A respiratory disorder
B) An anxiety disorder
C) A cardiovascular disorder
D) A congenital disorder
Answer: B
Explanation: A) Respiratory disorders are more likely to lead to respiratory acidosis.
B) Anxiety with hyperventilation is the most common cause of respiratory alkalosis. Therefore, anxiety disorders increase the risk for respiratory alkalosis.
C) Cardiovascular disorders do not usually lead to respiratory alkalosis.
D) Congenital disorders do not usually lead to respiratory alkalosis.
Page Ref: 29
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 1.D. Analyze respiratory alkalosis as it relates to acid-base balance. Compare the risk factors and prevention of respiratory alkalosis.
MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

15) A 2-month-old infant with pneumonia with respiratory alkalosis is believed to be experiencing paresthesias of the hands and feet, because the infant pulls away and cries when the extremities are touched. Which teaching will the nurse provide the parents to address the paresthesias?
A) Postural drainage techniques
B) Massage techniques
C) Breastfeeding techniques
D) Swaddling techniques
Answer: D
Explanation: A) Postural drainage techniques are used to clear the airway, not comfort the infant.
B) Massage techniques will likely cause additional discomfort for the infant; calming touch is needed instead.
C) A mother of a 2-month-old infant likely already understands breastfeeding techniques.
D) Comfort measures that may be successful for infants experiencing paresthesias include swaddling, calming touch, and speaking with a quiet voice.
Page Ref: 30
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.8 Promote self-care management. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 1.D. Analyze respiratory alkalosis as it relates to acid-base balance. Differentiate care of clients with respiratory alkalosis across the lifespan.

MNL LO: Demonstrate understanding of the concept of acid-base balance in the care of a patient with metabolic alkalosis.

Module 2 Cellular Regulation

The Concept of Cellular Regulation

1) The nurse is teaching a class to prospective parents about the role that deoxyribonucleic acid (DNA) plays in the development of the human fetus. Which statement made by the parents indicates understanding of the teaching?
A) "DNA molecules are made up of genes."
B) "DNA is used to form ribosomes."
C) "DNA is outside the nucleus of the cell."
D) "DNA is attached to the endoplasmic reticulum."
Answer: A
Explanation: A) DNA contains all the instructions, or genes, needed to determine an individual's inherited characteristics and produce every protein needed by the body.
B) RNA, not DNA, is used to form ribosomes.
C) DNA is located within the nucleus of the cell.
D) Ribosomes are found on the endoplasmic reticulum.
Page Ref: 34
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 2.1. Analyze the physiology of cellular regulation in the body.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

2) The nurse is reviewing the different cellular alterations. Which statement will the nurse make when asked to described hyperplasia?
A) "It is abnormal grown of specific tissue."
B) "It is a cell returning to an immature state."
C) "It is the replacement of one cell by another cell type."
D) "It is an increase in the number or density of normal cells."
Answer: D
Explanation: A) Dysplasia is characterized by disturbed cell growth of specific tissue.
B) Anaplasia is the regression of a cell to an immature or undifferentiated cell type.
C) Metaplasia is a reversible change in which one adult cell type is replaced by another adult cell type.
D) Hyperplasia is an increase in the number or density of normal cells.
Page Ref: 36
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.2. Differentiate alterations in cellular regulation.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

3) The nurse is preparing to perform a health assessment on an adult client who has a family history of cancer. Which question should the nurse ask to assess for the early warning signs of cancer? **Select all that apply.**
A) "Do you have a cough that is associated with seasonal allergies?"
B) "Have you noticed a change in your appetite?"
C) "Have you noticed any cuts that have not healed?"
D) "Have you had any changes in bowel or bladder habits?"
E) "Have you experienced any problems swallowing?"
Answer: C, D, E
Explanation: A) A cough that is associated with seasonal allergies is not associated with the early warning signs of cancer.
B) Changes in appetite are not associated with the early warning signs of cancer.
C) The early warning signs of cancer include a sore that does not heal.
D) The early warning signs of cancer include a change in bowel or bladder habits.
E) The early warning signs of cancer include difficulty swallowing.
Page Ref: 40
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment

Learning Outcome: 2.5. Differentiate common assessment procedures and tests used to examine cellular regulation.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

4) The nurse is caring for a client diagnosed with cancer. Which diagnostic tests may be helpful to assist with treatment options? **Select all that apply.**
A) Tumor markers
B) Urinalysis
C) Physical assessment
D) MRI
E) Stool analysis
Answer: A, B, D
Explanation: A) Many diagnostic tests are helpful in determining treatment for cancer. Tumor markers are all diagnostic tests that may be used to determine treatment for cancer.
B) Many diagnostic tests are helpful in determining treatment for cancer. Urinalysis may be used to determine treatment for cancer.
C) A physical assessment may be useful to determine how a client is responding to treatment, but it is not considered a diagnostic test.
D) Many diagnostic tests are helpful in determining treatment for cancer. An MRI may be used to determine treatment for cancer.
E) A stool analysis is not a diagnostic test listed to determine treatment for cancer.
Page Ref: 40-41
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 2.5. Differentiate common assessment procedures and tests used to examine cellular regulation.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

5) The nurse instructs a group of community members about ways to reduce the development of cancer. Which participant statements indicate that teaching has been effective? **Select all that apply.**

A) "I should eat at least two servings of fruits or vegetables each day."
B) "Sunscreen should be applied before spending time outdoors."
C) "I need to cut down on my smoking."
D) "I need to get my home tested for radon."
E) "I need to minimize my child's exposure to secondhand smoke."

Answer: B, D, E

Explanation: A) Efforts to reduce the development of cancer include eating five servings of fruits and vegetables each day.
B) Sunscreen should be used by those who spend time outside regularly for work or recreation.
C) All smoking should be discouraged.
D) The home should be tested for radon, which is a known cancer-causing substance.
E) Children should be protected from exposure to tobacco smoke.

Page Ref: 40
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 2.4. Explain the promotion of healthy cellular regulation.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

6) The nurse is caring for a client with leukemia. Which treatment should the nurse expect to be prescribed for this client?
A) Diuretic therapy
B) Chemotherapy
C) Electrolyte replacement therapy
D) IV fluid therapy
Answer: B
Explanation: A) Diuretics are not typically used to treat cancer, although they may be used if complications develop.
B) The client with an alteration in cell growth has cancer and will most likely be treated with chemotherapy.
C) Electrolyte replacement is not typically used to treat cancer, although it may be used if complications develop.
D) IV fluids are not typically used to treat cancer, although they may be used if complications develop.
Page Ref: 43
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.6. Describe how the strength and relevance of available evidence influences the choice of interventions in provision of patient-centered care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 2.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in cellular regulation.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

7) The nurse is caring for an adolescent client with a strong family history of breast cancer. Which information should the nurse include when instructing the client regarding cancer prevention? **Select all that apply.**
A) Encourage the client to learn more about the disease.
B) Talk to family members who have the disease.
C) Perform monthly breast self-examination.
D) Teach the side effects of cancer treatment.
E) Discuss cancer fears with the healthcare provider.
Answer: A, C
Explanation: A) When there is a familial history of cancer, the client should be encouraged to learn more about the cancer.
B) Talking to family members who have the disease will not help with early detection or prevention.
C) In families with a history of breast cancer, the nurse should inform clients about breast self-examination.
D) Teaching the side effects of cancer treatment would be appropriate if the client was diagnosed with breast cancer.
E) The client can discuss cancer fears with the nurse; however, this action will not help prevent the development of the disease.
Page Ref: 39-40
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 2.4. Explain the promotion of healthy cellular regulation.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

8) A client with anemia is prescribed synthetic erythropoietin. When teaching the client about the therapeutic effect of this treatment, which is appropriate for the nurse to include?
A) Increase in platelets
B) Increase in red blood cells
C) Decrease in white blood cells
D) Decrease in lymph fluid
Answer: B
Explanation: A) Erythropoietin will not stimulate the production of platelets.
B) Erythropoietin is a hormone produced in the body to stimulate production of red blood cells.
C) Erythropoietin will not decrease the production of white blood cells.
D) Erythropoietin will not decrease the production of lymph fluid.
Page Ref: 37
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 2.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in cellular regulation.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

9) The nurse is reviewing the concepts of human growth and development with a group of clients. Which statement indicates that teaching has been effective?
A) "The zygote undergoes differentiation to form a multicellular embryo, which becomes a fetus and then an infant."
B) "Meiosis occurs only in the sex cells of the testes and ovaries."
C) "Mitosis reduces the amount of genetic material by half."
D) "When the two sex cells combine during fertilization, a total of 50 chromosomes are present in the offspring's cells."
Answer: B
Explanation: A) The zygote undergoes mitosis to form a multicellular embryo, which becomes a fetus and then an infant.
B) Meiosis, which reduces the amount of genetic material by half, occurs only in the sex cells of the testes and ovaries.
C) Mitosis results in two cells, called daughter cells, that are genetically identical to the original cell and to each other.
D) When the two sex cells combine during fertilization, the total number of chromosomes present in the offspring's cells is 46, not 50.
Page Ref: 35-36
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 2.1. Analyze the physiology of cellular regulation in the body.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

10) The nurse is creating a teaching tool about methods of cellular transport. Which information about passive transportation will the nurse include in the tool?
A) Endocytosis
B) Facilitated diffusion
C) Exocytosis
D) Phagocytosis
Answer: B
Explanation: A) Active cellular transportation requires energy and includes endocytosis.
B) Passive cellular transportation does not require energy and includes facilitated diffusion.
C) Active cellular transportation requires energy and includes exocytosis.
D) Active cellular transportation requires energy and includes phagocytosis.
Page Ref: 34
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 2.1. Analyze the physiology of cellular regulation in the body.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

11) The nurse is caring for a client with cancer. Which cellular alterations in the cell cycle should the nurse include when teaching the client? **Select all that apply.**

A) Hyperplasia
B) Differentiation
C) Anaplasia
D) Dysphagia
E) Adaptation
Answer: A, C
Explanation: A) Hyperplasia is an increase in the number or density of normal cells, while anaplasia is the regression of a cell to an immature or undifferentiated cell type.
B) Differentiation is a normal process occurring over many cell cycles that allows cells to specialize in certain tasks.
C) Anaplasia is the regression of a cell to an immature or undifferentiated cell type.
D) Dysphagia is not a part of the cell cycle.
E) Adaptation is not a part of the cell cycle.
Page Ref: 36
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 2.2. Differentiate alterations in cellular regulation.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

12) The nurse is caring for a client with sickle cell anemia. Which type of hemoglobin causes the abnormal shape to the red blood cell?
A) Hgb A
B) Hgb S
C) Hgb B
D) Hgb E
Answer: B
Explanation: A) The abnormal sickle-shaped red blood cell in sickle cell anemia is not caused by an abnormal shape in Hgb A.
B) The inherited alteration of Hgb S causes the abnormal sickle-shaped red blood cell in sickle cell anemia.
C) The abnormal sickle-shaped red blood cell in sickle cell anemia is not caused by an abnormal shape in Hgb B.
D) The abnormal sickle-shaped red blood cell in sickle cell anemia is not caused by an abnormal shape in Hgb E.
Page Ref: 37
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.2. Differentiate alterations in cellular regulation.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

13) The nurse is planning care for a client with cancer. Which independent nursing intervention should the nurse include in the plan of care?
A) Administer pain and other medications
B) Help the client identify support systems
C) Design a diet that provides proper nutrition
D) Suggest contacting the nurse's spiritual leader
Answer: B
Explanation: A) Administering medications is a collaborative intervention.
B) Clients who are diagnosed with an alteration in cellular regulation will experience many different emotions, and they will need a proper support system to help them cope with the diagnosis and provide care when needed. The nurse can help the client identify a support system of friends, family, and support groups.
C) Nurses should refer clients to a dietitian for a diet plan.
D) The nurse should facilitate contact with the client's spiritual leader if desired, not the nurse's spiritual leader.
Page Ref: 41-42
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 2.6. Analyze independent interventions nurses can implement for patients with alterations in cellular regulation.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

14) The parents of a toddler being treated for sickle cell crisis are concerned because the child is wetting the bed despite being potty trained. Which statement should the nurse make to the parents?
A) "Your child is likely rebelling because of the treatments and needs discipline."
B) "Bedwetting is often a sign of urinary tract infection. I will have the provider check for that."
C) "Toddlers often regress in behaviors when they are sick. "
D) "Nocturnal enuresis is a side effect of the medications."
Answer: C
Explanation: A) Bedwetting is not usually a sign of rebellion.
B) Bedwetting may be a sign of a urinary tract infection but without additional signs or symptoms, this is less likely to be true.
C) A toddler who has been potty trained will often regress in behaviors and begin wetting the bed when faced with a stressful illness. It is important for the parents to understand that this is common and that the child will likely return to previous behaviors once the health crisis is past.
D) Bedwetting may be a side effect of medications, but without additional signs or symptoms, it is less likely to be true.
Page Ref: 45
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 2.8. Differentiate considerations related to the care of patients with alterations in cellular regulation throughout the lifespan.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

15) The nurse is caring for a pregnant client with a cellular regulation disorder. About which potential complication should the nurse include when teaching the client?
A) Gestational diabetes
B) Placenta previa
C) Urinary tract infection
D) Preeclampsia
Answer: D
Explanation: A) Gestational diabetes is not specifically related to cellular regulation disorders.
B) Placenta previa is not specifically related to cellular regulation disorders.
C) Urinary tract infection is not a serious complication.
D) A pregnant client with a cellular regulation disorder is at higher risk for preeclampsia during pregnancy.
Page Ref: 45
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Implementation
Learning Outcome: 2.8. Differentiate considerations related to the care of patients with alterations in cellular regulation throughout the lifespan.
MNL LO: Analyze the concept of cellular regulation and its application to nursing care.

Exemplar 2.A Cancer

1) A client with cancer is scheduled for chemotherapy before and after surgery. For which reason is chemotherapy scheduled at these times? **Select all that apply.**
A) Eradicate all cancer cells
B) Shrink the tumor
C) Kill remaining cancer cells
D) Allow the immune system to kill cancer cells
E) Improve wound healing
Answer: B, C
Explanation: A) It is impossible to eradicate all cancer cells with chemotherapy.
B) Chemotherapy before surgery is used to shrink the tumor.
C) Chemotherapy is used after surgery to kill remaining cancer cells.
D) The use of chemotherapy before and after surgery will not allow the immune system to kill the cancer cells.
E) Chemotherapy is not used to improve wound healing.
Page Ref: 61-62
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 2.A. Analyze cancer as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with cancer.

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2) The nurse instructs a group of community members on ways to reduce the risk of cancer. Which statements indicate that teaching has been effective? **Select all that apply.**
A) "I started using sunscreen when I work outside."
B) "I began drinking two glasses of red wine a day with dinner."
C) "I have reduced my intake of fiber."
D) "I have increased the amount of fried fish in my diet."
E) "I am trying to quit smoking."
Answer: A, E
Explanation: A) Sun exposure increases the risk of skin cancer, so using sunscreen when outdoors would indicate understanding.
B) Drinking two glasses of red wine daily is not an action that reduces cancer risk.
C) Increased fiber intake reduces the risk of colon cancer.
D) Increasing the amount of fried fish is not an action that reduces cancer risk.
E) Smoking increases the risk of lung and other types of cancer, so trying to quit smoking would indicate understanding.
Page Ref: 51
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 2.A. Analyze cancer as it relates to cellular regulation. Compare the risk factors , and prevention of, cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with cancer.

3) The nurse is preparing a seminar that discusses the risk and incidence of cancer and culture. Which information is considered culturally correct when teaching about the risk of developing cancer?

A) Black males and white females are more likely to develop cancer than any other ethnic group.

B) Native Americans have the highest incidence of prostate cancer.

C) The incidence and mortality rate of all types of cancers are lowest in the Caucasian population.

D) The Hispanic population has the lowest mortality rate of any racial or ethnic group.

Answer: A

Explanation: A) Black males and white females more likely to develop cancer than any other ethnic group in the US.

B) Native Americans and Asians have the lowest incidence of prostate cancer.

C) Cancer incidence and mortality are lower in Native American men and women than in any other ethnic or racial group.

D) Mortality rates are lowest among the Asian/Pacific Islander population.

Page Ref: 47

Cognitive Level: Applying

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 2.A. Analyze cancer as it relates to cellular regulation. Compare the risk factors for, and prevention of, cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with cancer.

4) A preschool-age child has an appointment in a pediatric oncology clinic. Which reactions are considered common for the preschool-age child to experience with illnesses and hospitalizations? **Select all that apply.**
A) Unawareness of the illness and its severity
B) Understanding of what cancer is and how it is treated
C) Thoughts that they caused their illness and are being punished
D) Confusion as to why a parent is unable to make the illness go away
E) Acceptance, especially if able to discuss the disease with children their own age
Answer: C, D
Explanation: A) Infants and toddlers are unaware of the severity of the disease.
B) School-age children can understand a diagnosis of cancer.
C) Preschoolers are beginning to understand illness. However, they may think they caused their illness.
D) Preschoolers are beginning to understand illness. However, they may be confused about why the parent cannot make the illness go away.
E) Immediate acceptance will not occur with children of any age. Adolescents find contact with others who have gone through their experience helpful.
Page Ref: 65
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.1 Engage with the individual in establishing a caring relationship. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 2.A. Analyze cancer as it relates to cellular regulation. Differentiate considerations for care of patients with cancer across the lifespan.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with cancer.

5) A client being treated for cancer has a tumor designation of Stage IV, T4, N3, M1. Which information does this staging provide to the nurse?
A) The tumor will respond to chemotherapy.
B) The tumor is small in size.
C) The tumor has metastasized with lymph node involvement.
D) There is one single tumor to treat.
Answer: C
Explanation: A) The staging system is not used to determine tumor response to chemotherapy.
B) The numbers range from 0 to 4, with higher numbers indicating increased size and metastasis.
C) T refers to the depth of invasion. N refers to the absence or presence and extent of lymph node involvement. M refers to presence of metastasis.
D) Stage IV indicates metastasis.
Page Ref: 57
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.A. Analyze cancer as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with cancer.

6) The nurse is providing discharge instructions to a client being treated for cancer. For which symptoms should the client be instructed to call for help at home? **Select all that apply.**

A) Difficulty breathing
B) Significant increase in vomiting
C) Desire to end life
D) Improved sense of well-being
E) New onset of bleeding

Answer: A, B, C, E

Explanation: A) The client should be instructed to call for help with any difficulty breathing.
B) The client should be instructed to call for help with any significant increase in vomiting.
C) The client should be instructed to call for help with a desire to end life.
D) An increased sense of well-being would be a desired effect of treatment for cancer.
E) The client should be instructed to call for help with a new onset of bleeding.

Page Ref: 70
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 2.A. Analyze cancer as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with cancer.

7) The nurse instructs a group of community members on the difference between benign and malignant neoplasms. Which participant statements indicate that teaching has been effective? **Select all that apply.**

A) "Benign tumors grow slowly."
B) "Malignant tumors are easy to remove."
C) "Benign tumors stay in one area."
D) "Malignant tumors crowd out surrounding tissue."
E) "Malignant tumors can grow back."

Answer: A, C, E

Explanation: A) Benign tumors are slow-growing.
B) Malignant tumors are more difficult to remove.
C) Benign tumors stay in one area.
D) Malignant tumors invade neighboring tissue.
E) Malignant tumors can return once removed.

Page Ref: 47
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 2.A. Analyze cancer as it relates to cellular regulation. Describe the pathophysiology of cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with cancer.

8) A client with cancer is receiving chemotherapy and has lost 10 lbs. over the past week. Which instruction should the nurse give to this client to improve nutritional status? **Select all that apply.**

A) Purchase fast foods and prepared foods.
B) Eat cold foods rather than hot foods.
C) Keep a food diary and record intake.
D) Eat large frequent meals high in calories.
E) Drink liquid supplements to increase intake of nutrients.

Answer: B, C, E

Explanation: A) Fast foods and prepared foods tend to be high in fat and sodium and are not the best choice because they do not contain adequate healthy nutrients.
B) The client receiving chemotherapy may tolerate cold foods better than hot foods.
C) The goal of nutritional teaching is to help the client increase caloric and nutrient intake through the use of a food diary that will help the nurse evaluate strengths and weaknesses of the current plan.
D) The client will unlikely tolerate large frequent meals that are high in calories.
E) The goal of nutritional teaching is to help the client increase caloric and nutrient intake through the use of liquid supplements.

Page Ref: 72
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 2.A. Analyze cancer as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with cancer.

9) The nurse is reviewing the process of carcinogenesis. Which change occurs during the initiation stage?

A) DNA changes are passed on to more cells during cell replication.

B) A carcinogen causes permanent damage to DNA.

C) A carcinogen acts repeatedly on cells with damaged DNA.

D) A gene is activated that promotes cell proliferation.

Answer: C

Explanation: A) The progression stage involves inherited changes that are acquired during cell replication developing into a cancer.

B) The promotion stage involves conditions such as smoking or alcohol use that act repeatedly on the already affected cells.

C) The initiation stage involves permanent damage in the cellular DNA as a result of exposure to a carcinogen.

D) Oncogenes are genes that promote cell proliferation; they are not part of the carcinogenic process.

Page Ref: 49

Cognitive Level: Remembering

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 2.A. Analyze cancer as it relates to cellular regulation. Describe the etiology of cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with cancer.

10) The nurse is caring for a client with cancer. Which assessment will the nurse make to monitor for the development of cachexia?
A) Weight
B) Blood pressure
C) Heart rate
D) Temperature
Answer: A
Explanation: A) Cachexia is a wasting syndrome associated with cancer that includes malnutrition and unexplained loss of weight and muscle mass. Monitoring weight is the assessment to determine if cachexia is developing.
B) Cachexia is unrelated to blood pressure.
C) Cachexia is unrelated to heart rate.
D) Cachexia is unrelated to body temperature.
Page Ref: 71
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.A. Analyze cancer as it relates to cellular regulation. Identify the clinical manifestations of cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with cancer.

Exemplar 2.B Anemia

1) A client who had gastric bypass surgery one year ago has a beefy, red, and smooth tongue and a yellow cast to the skin. Which additional information is needed before diagnosing this client?
A) Folic acid level
B) Vitamin B_{12} levels
C) Potassium levels
D) Iron levels
Answer: B
Explanation: A) Jaundice is not associated with folic acid deficiency anemia.
B) Vitamin B_{12} deficiency is associated with resection of the stomach or ileum. A deficiency of vitamin B_{12} will result in pernicious anemia. This deficiency will manifest as pallor, jaundice, weakness, and a beefy, smooth, red tongue.
C) The client's reports are not consistent with a potassium deficiency.
D) Iron deficiency anemia will manifest with weakness and fatigue.
Page Ref: 79
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes.
AACN Domain and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.B. Analyze anemia as it relates to cellular regulation. Identify the clinical manifestations of anemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with anemia.

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2) A client experiencing fatigue, pallor, and dyspnea on exertion has a complete blood count drawn. Which red blood cell disorder should the nurse anticipate the client is experiencing?
A) Polycythemia
B) Erythropoiesis
C) Herpes simplex
D) Anemia
Answer: D
Explanation: A) Polycythemia is an abnormally high RBC count.
B) Erythropoiesis is the term for RBC production.
C) Herpes simplex is not a red blood cell disorder.
D) Anemia is a common red blood cell disorder, involving a low RBC count and decreased hemoglobin content. Signs and symptoms of anemia can include pallor of the skin and mucous membranes and dyspnea on exertion.
Page Ref: 75
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.B. Analyze anemia as it relates to cellular regulation. Identify the clinical manifestations of anemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with anemia.

3) A client with a history of anemia has started a vegan diet. Which addition to meals should the nurse recommend to help ensure that this client has adequate amounts of iron in the diet? **Select all that apply.**

A) Legumes
B) Orange juice
C) Yeast
D) Okra
E) Peas

Answer: A, B, E

Explanation: A) While all these options are good ones for someone on a vegan diet, the ones that would best prevent iron deficiency are legumes, peas, and orange juice. Legumes are good sources of nonheme iron.

B) Orange juice supports iron absorption from foods since it is high in vitamin C.

C) Yeast is a good source of folic acid.

D) Okra is not a good source of iron.

E) While all these options are good ones for someone on a vegan diet, the ones that would best prevent iron deficiency are legumes, peas, and orange juice. Peas are good sources of nonheme iron.

Page Ref: 83

Cognitive Level: Applying

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 2.B. Analyze anemia as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with anemia.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with anemia.

4) An older adult client with renal failure is diagnosed with anemia. For which cause of anemia will the nurse plan care for this client?
A) Loss of the kidney hormone erythropoietin
B) A loss of appetite related to elevated blood urea nitrogen (BUN) and creatinine levels
C) The renal dialysis used to treat the chronic renal failure
D) Loss of blood through the urine because the failing kidney does not function properly
Answer: A
Explanation: A) The anemia associated with renal failure is related to the loss of erythropoietin, which is produced by the healthy kidney and stimulates bone marrow to produce red blood cells.
B) The anemia is not directly related to anorexia changes in laboratory values.
C) The anemia is not directly related to hemodialysis.
D) Renal failure causes the loss of protein, not blood, through the urine.
Page Ref: 82
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 2.B. Analyze anemia as it relates to cellular regulation. Describe the etiology of anemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with anemia.

5) A nursing student is preparing an educational program on acquired hemolytic anemia for the residents of an assisted living center. Which causes of acquired hemolytic anemia should the student include in the program? **Select all that apply.**

A) Bacterial infection
B) Thalassemia
C) Blood transfusion reaction
D) Prosthetic heart valves
E) Acetaminophen use

Answer: A, C, D

Explanation: A) Bacterial infections are acquired hemolytic anemia.
B) Thalassemia is considered an intrinsic cause of hemolytic anemia and would not be appropriate to include in this particular teaching.
C) Blood transfusion reactions are causes of acquired hemolytic anemia.
D) Prosthetic heart valves are causes of acquired hemolytic anemia.
E) Acetaminophen use is not associated with hemolytic anemia.

Page Ref: 80-81
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 2.B. Analyze anemia as it relates to cellular regulation. Describe the etiology of anemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with anemia.

6) A client with severe anemia experiences shortness of breath when walking short distances. Which problem will the nurse make a priority for this client's care?

A) Self-neglect
B) Inability to tolerate activity
C) Inadequate gas exchange
D) Acute pain

Answer: B

Explanation: A) There is no evidence that the client is experiencing self-neglect.
B) Inability to tolerate activity would be the priority problem for this client.
C) There is no evidence that the client is experiencing inadequate gas exchange.
D) There is no evidence that the client is experiencing acute pain.

Page Ref: 84

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 2.B. Analyze anemia as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with anemia.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with anemia.

7) The nurse is evaluating a client's understanding of dietary needs to treat a nutritional deficiency anemia. Which client statement indicates a need for additional teaching?
A) "I will eat more fruits and vegetables, especially green leafy ones, to get more iron in my diet."
B) "I will need to include more protein foods in my diet such as meats, dried beans, and whole-grain breads."
C) "I will decrease foods high in vitamin C, as they decrease my absorption of iron."
D) "I will take vitamins with extra iron in addition to eating a balanced diet with meat to correct my anemia."
Answer: C
Explanation: A) Green leafy vegetables will increase iron in the diet.
B) Protein foods such as meats, dried beans, and whole-grain breads contain iron that will help dietary deficiency anemia.
C) Increasing foods high in vitamin C will increase absorption of iron.
D) The lack of iron is the problem that needs to be addressed. Extra iron is needed to help replace RBCs and treat the dietary deficiency anemia.
Page Ref: 76
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 2.B. Analyze anemia as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with anemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with anemia.

8) The nurse suspects that a client with severe shortness of breath in the absence of cyanosis is experiencing anemia. Which laboratory tests should the nurse review to confirm anemia? **Select all that apply.**
A) Serum electrolytes
B) Cardiac enzymes
C) Hemoglobin
D) Blood sugar
E) Hematocrit
Answer: C, E
Explanation: A) Serum electrolytes do not cause anemia.
B) Cardiac enzymes do not cause anemia.
C) Severe anemia will interfere with the development of cyanosis, so the nurse should review the hemoglobin.
D) Blood sugar does not cause anemia.
E) Severe anemia will interfere with the development of cyanosis, so the nurse should review the hematocrit.
Page Ref: 81
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.B. Analyze anemia as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with anemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with anemia.

9) The nurse is caring for a client with hemolytic anemia. When planning care for this client, which should the nurse take into consideration regarding this diagnosis?
A) It causes the red blood cells to be microcytic.
B) It is associated with a decrease in the reticulocyte count.
C) It is the result of blood loss.
D) It is a result of the premature destruction of red blood cells.
Answer: D
Explanation: A) Hemolytic anemias are normocytic (red blood cells are normal size), not microcytic.
B) Hemolytic anemia causes an increase, not a decrease, in the reticulocyte (immature red blood cells) count because they are released early from the bone marrow to compensate.
C) Hemolytic anemia is not associated with blood loss.
D) Hemolytic anemia is caused by the premature destruction of the red blood cells.
Page Ref: 81
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 2.B. Analyze anemia as it relates to cellular regulation. Describe the etiology of anemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with anemia.

10) The nurse is instructing a client with iron deficiency anemia about appropriate menu choices. Which diet choice indicates that teaching has been effective?

A) Tofu with mixed vegetables in curry, milk, whole-wheat bun
B) Broiled fish, lettuce salad, grapefruit half, carrot sticks
C) Pork chop, mashed potatoes and gravy, cauliflower, tea
D) Roast beef, steamed spinach, tomato soup, orange juice

Answer: D

Explanation: A) The meal of tofu with mixed vegetables in curry, milk, and a whole-wheat bun is high in calcium, but the client has iron deficiency anemia and requires a high-iron diet.

B) The meal of fish, lettuce, grapefruit, and carrot sticks is high in fiber, low in fat, and moderately high in protein, but low in iron.

C) The meal with a pork chop, mashed potatoes and gravy, cauliflower, and tea has a moderate amount of protein, but no vitamin C.

D) This client is anemic and needs iron. This meal contains iron in the beef, folic acid and iron in the spinach, and vitamin C in the tomato soup and orange juice. Vitamin C helps absorption of the iron; folic acid is needed for production of red cells.

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Cognitive Level: Analyzing

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 2.B. Analyze anemia as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with anemia.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with anemia.

11) The nurse is educating a client with anemia about the pathophysiological mechanisms of anemia. Which should be excluded in the nurse's teaching plan for this client?
A) Altered hemoglobin synthesis
B) Altered DNA synthesis
C) Decreased hemolysis
D) Bone marrow failure
Answer: C
Explanation: A) The pathophysiological mechanisms of anemia include altered hemoglobin synthesis.
B) The pathophysiological mechanisms of anemia include altered DNA synthesis.
C) The pathophysiological mechanisms of anemia includes increased hemolysis.
D) Bone marrow failure is the mechanism in aplastic anemia, red cell aplasia, myeloproliferative leukemias, and lymphomas.
Page Ref: 75
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Essential Competencies 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.B. Analyze anemia as it relates to cellular regulation. Describe the etiology of anemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with anemia.

12) The nurse is providing discharge instructions to a client with iron deficiency anemia who is experiencing glossitis. Which statements will the nurse include in the discharge teaching for this client? **Select all that apply.**

A) Monitor the condition of the lips and tongue daily.
B) Use an alcohol-based mouthwash every 2 to 4 hours.
C) Provide frequent oral hygiene.
D) Apply a non-petroleum-based lubricating jelly or ointment to the lips after oral care.
E) Use a soft toothbrush or sponge to provide oral care.

Answer: A, C, E

Explanation: A) Glossitis, inflammation of the tongue that may cause the tongue and lips to turn red, and cheilosis (fissures or cracks at the corners of the mouth) may occur with nutritional deficiencies of iron, folate, and vitamin B_{12}. Client education should include monitoring the condition of lips and tongue daily.

B) The client should not use an alcohol-based mouthwash, as this would worsen the glossitis.

C) Glossitis, inflammation of the tongue that may cause the tongue and lips to turn red, and cheilosis (fissures or cracks at the corners of the mouth) may occur with nutritional deficiencies of iron, folate, and vitamin B_{12}. Client education should recommend providing frequent oral hygiene.

D) The client should use a petroleum-based lubricating jelly or ointment to the lips after oral care.

E) Glossitis, inflammation of the tongue that may cause the tongue and lips to turn red, and cheilosis (fissures or cracks at the corners of the mouth) may occur with nutritional deficiencies of iron, folate, and vitamin B_{12}. Client education should include oral hygiene with a soft-bristle toothbrush or sponge.

Page Ref: 85
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 2.B. Analyze anemia as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with anemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with anemia.

13) The nurse is reviewing the different types of anemia. Which form of anemia can be prevented by a change in diet?
A) Iron deficiency anemia
B) Aplastic anemia
C) Blood loss anemia
D) Hemolytic anemia
Answer: A
Explanation: A) Nutritional causes of anemia include iron deficiency, vitamin B_{12} deficiency, and folic acid deficiency. Only nutritional anemias can be prevented by a change in diet.
B) Aplastic anemia occurs when the bone marrow fails to produce red and white blood cells.
C) Blood loss anemia recurs as a result of hemorrhage or other forms of blood loss.
D) Hemolytic anemias occur when red blood cells are destroyed prematurely.
Page Ref: 78
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.B.3. Analyze anemia as it relates to cellular regulation. Compare the risk factors for and prevention of anemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with anemia.

14) The nurse is caring for several newborns with anemia. Which infant with anemia would the nurse be *least* concerned about?
A) A baby born at 32 weeks' gestation after the mother suffered from abruptio placentae
B) A baby born at 38 weeks' gestation who has a blood group incompatibility with the mother
C) A baby born at 35 weeks' gestation who suffered birth trauma to the head
D) A baby born at 39 weeks' gestation via a scheduled cesarean section
Answer: D
Explanation: A) The infants who experienced abruptio placentae may have anemia related to blood loss or hemolysis, which is much more serious than physiologic anemia of the newborn.
B) The infants who experienced blood group incompatibility may have anemia related to blood loss or hemolysis, which is much more serious than physiologic anemia of the newborn.
C) The infants who experienced birth trauma may have anemia related to blood loss or hemolysis, which is much more serious than physiologic anemia of the newborn.
D) For full-term infants with no birth complications, a normal, gradual drop in hemoglobin during the first 6 to 12 weeks of life is called physiologic anemia of the newborn. When the hemoglobin begins to drop, the bone marrow produces RBCs again, and the anemia disappears.
Page Ref: 84
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment
Learning Outcome: 2.B. Analyze anemia as it relates to cellular regulation. Differentiate considerations for care of patients with anemia across the lifespan.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with anemia.

Exemplar 2.C Breast Cancer

1) The nurse is reviewing data collected during a health history with a client. Which data supports this client's risk for developing breast cancer? **Select all that apply.**
A) Age 60
B) Breastfed both children
C) Sister had breast cancer
D) Body mass index 22
E) Menopause at age 58
Answer: A, C, E
Explanation: A) The risk for developing breast cancer increases with age.
B) Breastfeeding lowers a person's risk for developing breast cancer.
C) Having a first-degree relative with breast cancer increases the risk.
D) Maintaining a normal body weight lowers a person's risk for developing breast cancer.
E) Menopause after the age of 55 increases the risk for developing breast cancer.
Page Ref: 88
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.C. Analyze breast cancer as it relates to cellular regulation. Compare the risk factors for, and prevention of, breast cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with breast cancer.

2) The nurse is instructing a group of women between the ages of 40 and 50 about early detection of breast cancer. Which information should the nurse include in this teaching?
A) Perform annual breast self-exams.
B) See a healthcare provider if there is a strong family history of breast cancer.
C) Have a yearly mammogram.
D) Have a clinical breast exam performed by a healthcare provider every 5 years.
Answer: C
Explanation: A) Breast self-exam should be done monthly.
B) Discussing a family history of breast cancer would be part of the annual breast exam performed by a healthcare provider.
C) Yearly mammography for all women over the age of 45 is encouraged, as it decreases the mortality from breast cancer, and women between ages 40 and 45 can choose to have a mammogram annually.
D) It is inappropriate for women in this age group to have a clinical breast exam every 5 years.
Page Ref: 90
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 2.C. Analyze breast cancer as it relates to cellular regulation. Compare the risk factors for, and prevention of, breast cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with breast cancer.

3) The nurse is providing education regarding possible treatment options for a client who was recently diagnosed with breast cancer. Which options will the nurse include in the teaching session? **Select all that apply.**

A) Mastectomy
B) Hormone therapy
C) Breast-conserving surgery
D) Palliative care
E) Radiation

Answer: A, B, C, E

Explanation: A) Treatment options appropriate for a client newly diagnosed with breast cancer may include mastectomy.

B) Treatment options appropriate for a client newly diagnosed with breast cancer may include hormone therapy.

C) Treatment options appropriate for a client newly diagnosed with breast cancer may include breast-conserving surgery.

D) Palliative care will only be implemented once the client's cancer is considered to be terminal in nature.

E) Treatment options appropriate for a client newly diagnosed with breast cancer may include radiation.

Page Ref: 90

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 2.C. Analyze breast cancer as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with breast cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with breast cancer.

4) A client prescribed tamoxifen (Nolvadex) for breast cancer treatment asks the nurse how the medication works. Which response will the nurse make?
A) "Tamoxifen works by inhibiting the cellular mitosis of breast cancer."
B) "Tamoxifen works by blocking estrogen receptors on breast tissue."
C) "Tamoxifen works by binding to the DNA of breast cancer cells."
D) "Tamoxifen works by inhibiting the metabolism of breast cancer cells."
Answer: B
Explanation: A) Tamoxifen does not inhibit the cellular mitosis of breast cancer.
B) Breast cancer is dependent on estrogen for growth. Tamoxifen (Nolvadex) acts by blocking estrogen receptors; the tumor is deprived of estrogen.
C) Tamoxifen does not bind to the DNA of breast cancer cells.
D) Tamoxifen does not inhibit the metabolism of breast cancer cells.
Page Ref: 92
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 2.C. Analyze breast cancer as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with breast cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with breast cancer.

5) The nurse instructs a client recovering from a mastectomy on ways to prevent lymphedema. Which client statement indicates that teaching has been successful?
A) "I should do the exercises on my affected arm every day."
B) "I have to take no special precautions."
C) "I should avoid cleansing my skin with soap."
D) "Eating fresh fruits and vegetables will prevent my arm from swelling."
Answer: A
Explanation: A) Range-of-motion exercises in the affected arm help develop collateral drainage and prevent the development of lymphedema.
B) The client should be instructed to protect the affected limb by not permitting blood pressure measurement and avoiding tight jewelry and clothing on the limb.
C) There is no reason for the client to avoid cleansing the skin of the affected arm with soap.
D) Consuming fresh fruits and vegetables will not prevent the development of lymphedema.
Page Ref: 96
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 2.C. Analyze breast cancer as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with breast cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with breast cancer.

6) While completing a physical examination, the nurse suspects a client has breast cancer. Which finding caused the nurse to make this clinical determination? **Select all that apply.**
A) Rash along the inside of the right arm
B) Left nipple retraction
C) Palpable lump in the upper outer right quadrant
D) Scaliness near the right nipple
E) Pain when extending the left arm
Answer: B, C, D
Explanation: A) A rash on the arm is not a manifestation of breast cancer.
B) Manifestations of breast cancer include nipple retraction.
C) Manifestations of breast cancer include a palpable lump, usually in the upper outer quadrant.
D) Manifestations of breast cancer include scaliness of the skin.
E) Arm pain upon extension is not a manifestation of breast cancer.
Page Ref: 90
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.C. Analyze breast cancer as it relates to cellular regulation. Identify the clinical manifestations of breast cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with breast cancer.

7) The nurse is reviewing the pathophysiology of breast cancer. Which form of breast cancer is the most malignant form?
A) Infiltrating ductal carcinoma
B) Inflammatory carcinoma of the breast
C) Carcinoma of the mammary ducts
D) Paget disease
Answer: B
Explanation: A) Infiltrating ductal carcinoma is the most common type of breast cancer.
B) The most malignant form of breast cancer is inflammatory carcinoma of the breast, which is a systemic disease.
C) Carcinoma of the mammary ducts is a category of breast cancer.
D) Paget disease is an atypical breast cancer.
Page Ref: 87
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.C. Analyze breast cancer as it relates to cellular regulation. Describe the pathophysiology of breast cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with breast cancer.

8) A client has a family history of breast cancer, and genetic testing has revealed a mutation in *BRCA2*. Which mechanism would cause this client to develop breast cancer?
A) The cells' ability to accurately translate the RNA was impaired
B) The cells underwent mitosis rather than meiosis
C) The cells' ability to suppress tumor growth was impaired
D) The cells were stimulated to undergo rapid cell division
Answer: C
Explanation: A) *BRCA1* and *BRCA2* do not impair translation of RNA to protein.
B) Only germ cells undergo meiosis, not cancer cells.
C) Both *BRCA1* and *BRCA2* are tumor suppressor genes that help prevent the overstimulation of cell growth. If one or both are mutated, the cell's ability to suppress tumor growth is impaired.
D) *BRCA1* and *BRCA2* do not stimulate cells to undergo rapid cell division.
Page Ref: 88
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment
Learning Outcome: 2.C. Analyze breast cancer as it relates to cellular regulation. Describe the etiology of breast cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with breast cancer.

9) The client is caring for a client recovering from surgery for breast cancer. For which reason will the nurse instruct the client to avoid wearing deodorant on the affected side?
A) Deodorant can stimulate tumor growth in remaining cancer cells.
B) Deodorant can inhibit the production of sweat, which stimulates healing.
C) Deodorant can harbor bacteria and increase the client's risk for infection.
D) Deodorant can irritate the skin and slow the healing process.
Answer: D
Explanation: A) Deodorant does not stimulate tumor growth.
B) Although deodorant with an antiperspirant may inhibit sweat production, sweat does not contribute to the healing process.
C) Deodorant does not harbor bacteria.
D) Substances like deodorant and talcum powder can irritate the skin and impede healing.
Page Ref: 95
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 2.C. Analyze breast cancer as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with breast cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with breast cancer.

10) The nurse is providing community teaching related to risk factors for breast cancer for a group of young women. Which woman would the nurse identify as being at a higher risk for developing breast cancer at a young age?

A) A 28-year-old woman who received radiation for a spinal cord tumor at L3 during childhood
B) A 26-year-old woman who had a 32-year-old brother with breast cancer
C) A 34-year-old woman who has breastfed four children
D) A 42-year-old woman who has a second cousin diagnosed with breast cancer at age 58
Answer: B
Explanation: A) The 28-year-old woman had radiation therapy, but not to the breast or chest.
B) The risk factors include having a close relative, such as a parent or sibling, or a male relative who has had breast cancer.
C) Breastfeeding is a protective factor for developing breast cancer.
D) The 42-year-old woman had a relative, but not a close relative, with breast cancer.
Page Ref: 88
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment
Learning Outcome: 2.C. Analyze breast cancer as it relates to cellular regulation. Differentiate considerations for care of patients with breast cancer across the lifespan.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with breast cancer.

11) The nurse is caring for a 78-year-old client who was recently diagnosed with breast cancer. Which action will the nurse take that would be inappropriate for a younger client?
A) Discussing the woman's life expectancy
B) Arranging transportation to appointments
C) Ensuring the woman has adequate emotional support
D) Providing teaching related to breast-conservation treatments
Answer: B
Explanation: A) All clients with breast cancer should receive information related to life expectancy.
B) Older women may not have access to transportation if they or their partner do not drive. The nurse may need to help arrange transportation to appointments for these women.
C) Older women are less likely to show emotional distress compared to younger women.
D) All clients with breast cancer should receive information related to breast-conservation techniques.
Page Ref: 94
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 2.C. Analyze breast cancer as it relates to cellular regulation. Differentiate considerations for care of patients with breast cancer across the lifespan.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with breast cancer.

Exemplar 2.D Colorectal Cancer

1) The nurse is talking with a client who asked for information about colorectal cancer. Which statement indicates the teaching was effective?

A) The risk of colorectal cancer decreases with age.

B) Colorectal cancer can be detected in early stages by measuring the level of the carcinogenic embryonic antigen (CEA).

C) Colorectal cancer occurs more frequently in clients who have a history of inflammatory bowel disease.

D) Colorectal cancer has no symptoms in the early stage and there are no definitive diagnostic tests.

Answer: C

Explanation: A) Being over age 50 is a risk factor for colorectal cancer.

B) Carcinogenic embryonic antigen (CEA) is not considered a diagnostic test but is used as a tumor marker to follow and manage the disease in clients diagnosed with the disease.

C) The incidence of colorectal cancer is increased in clients with a history of inflammatory bowel disease.

D) Colorectal cancer is asymptomatic in the early stages. Screening tools such as annual fecal occult blood testing and colonoscopy performed every 10 years can detect the cancer when it is still in the curable stage.

Page Ref: 98

Cognitive Level: Analyzing

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 2.D. Analyze colorectal cancer as it relates to cellular regulation. Compare the risk factors for, and prevention of, colorectal cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with colorectal cancer.

2) The nurse provides an educational session for community members about the risk factors for colorectal cancer. Which participant statement indicates that teaching has been effective? **Select all that apply.**

A) "There is a genetic link in the development of colorectal cancer."

B) "People with other bowel diseases are at increased risk for developing this cancer."

C) "Eating a diet high in red meat reduces the risk for developing this type of cancer."

D) "Eating cereal fiber reduces the risk of developing colorectal cancer."

E) "Taking aspirin and a multivitamin each day reduces the risk of colorectal cancer."

Answer: A, B, E

Explanation: A) Genetic factors are strongly linked to the risk for colorectal cancer. Family history of the disease increases an individual's risk for its development.

B) Inflammatory bowel diseases increase the risk of colorectal cancer.

C) The disease is prevalent in people who consume diets high in meat proteins.

D) Cereal fiber does not play a role in the development of colorectal cancer.

E) The use of aspirin and multivitamins may reduce the risk of developing colorectal cancer.

Page Ref: 98-99

Cognitive Level: Analyzing

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 2.D. Analyze colorectal cancer as it relates to cellular regulation. Compare the risk factors for, and prevention of, colorectal cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with colorectal cancer.

3) A client recovering from surgery to place a permanent colostomy as treatment for colon cancer is concerned that the spouse will not want to have sexual relations. Which response by the nurse is the most appropriate?

A) "Tell me more about the concerns you are having."

B) "Would you like me to speak with your spouse?"

C) "Do not worry about sex right now. It is more important to focus on recovery."

D) "I will refer you to a counselor to talk about your concerns."

Answer: A

Explanation: A) Since the client has expressed concern to the nurse regarding sexual functioning, the nurse should ask the client to expand upon why there are concerns.

B) Offering to speak to the spouse is not an appropriate response at this time.

C) Telling the client not to worry about the concern is not an appropriate response at this time.

D) Although a referral may be needed for the client at some point, this is not the most appropriate response by the nurse.

Page Ref: 105

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 2.D. Analyze colorectal cancer as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with colorectal cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with colorectal cancer.

4) A client has just been told that a colectomy and ileostomy are needed to treat a new diagnosis of colon cancer. Which problem should the nurse use to plan this client's preoperative nursing care?
A) Potential fluid imbalances
B) Altered electrolyte levels
C) Potential for infection
D) Anticipatory grieving
Answer: D
Explanation: A) There is no evidence that the client will have a fluid imbalance.
B) There is no evidence that the client will have altered electrolyte levels.
C) There is no evidence that the client is at risk for an infection.
D) The client and family will require support to deal with their emotional response to learning the client has cancer and will undergo body image-changing surgery.
Page Ref: 104
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 2.D. Analyze colorectal cancer as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with colorectal cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with colorectal cancer.

5) The nurse is evaluating care provided to a client recovering from surgery for colorectal cancer. Which outcomes indicate that care has been successful? **Select all that apply.**

A) Client reports pain level as an 8 on a rating scale of 0 to 10.

B) Client has an hourly urine output of 45 mL.

C) Client performs morning care with assistance.

D) Client states family members will care for the ostomy at home.

E) Client tolerates full liquid diet and is requesting solid food.

Answer: B, C, E

Explanation: A) Pain rating should be at a level or 3 or less as evidence of successful care.

B) Evidence that care has been effective includes an adequate hourly urine output of at least 0.5 mL/kg/hr.

C) Evidence that care has been effective includes an ability to perform activities of daily living.

D) Not participating in the care of an ostomy and stating that family will provide the care needed are evidence of ineffective coping, an undesirable outcome.

E) Evidence that care has been effective includes tolerating oral intake.

Page Ref: 106

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

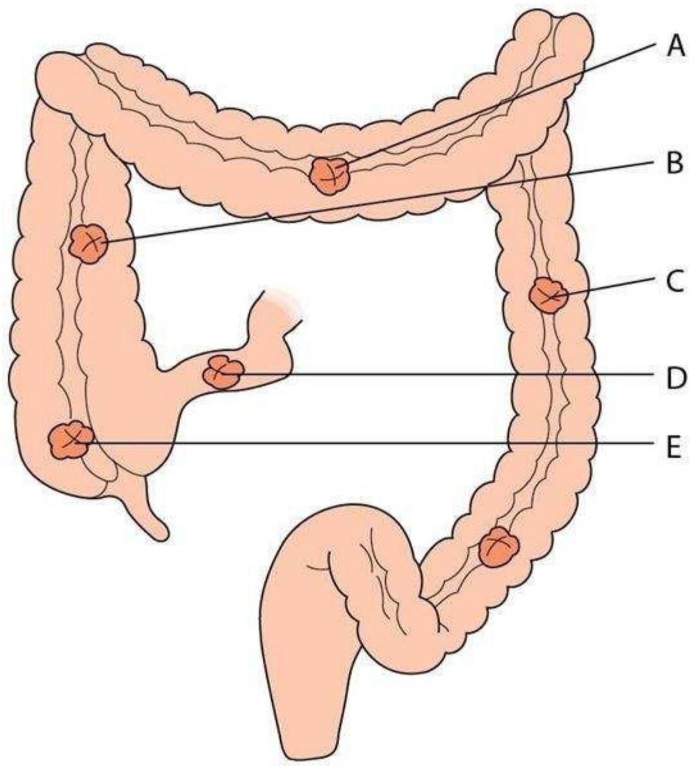
Learning Outcome: 2.D. Analyze colorectal cancer as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with colorectal cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with colorectal cancer.

6) The nurse is caring for a client who has had a double-barrel colostomy. Which is true regarding the proximal stoma? **Select all that apply.**
A) It is also called the mucous fistula.
B) It diverts feces to the abdominal wall.
C) It expels mucus from the distal colon.
D) It is a functional stoma.
E) It expels mucus from the proximal colon.
Answer: B, D
Explanation: A) The distal stoma is also called the mucous fistula.
B) When a double-barrel colostomy is performed, two separate stomas are created. The distal colon is not removed, but bypassed. The proximal stoma diverts feces to the abdominal wall.
C) The distal stoma expels mucus from the distal colon.
D) The proximal stoma is functional.
E) The distal stoma expels mucus from the distal colon.
Page Ref: 101
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.D. Analyze colorectal cancer as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with colorectal cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with colorectal cancer.

7) The nurse is caring for a client with colorectal cancer who is postoperative from a transverse colostomy placement. Which area of the bowel is involved?



W . B M.Ws

A) A
B) B
C) C
D) D
E) E
Answer: A
Explanation: A) Colostomies take the name of the portion of the colon from which they are formed. The transverse colon is the area of the bowel involved.
B) This is the site for an ascending colostomy.
C) This is the site of a descending colostomy.
D) This is the site for an ileostomy.
E) This is the site for a cecostomy.
Page Ref: 101
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.D. Analyze colorectal cancer as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with colorectal cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with colorectal cancer.

8) A client has colorectal cancer at stage I, T2. Which area has the tumor invaded?
A) The submucosa of the bowel
B) The muscularis propria of the bowel
C) The perirectal tissues
D) The lymph nodes
Answer: B
Explanation: A) A tumor with stage T1 has invaded the submucosa.
B) A tumor with the stage T2 has invaded the muscularis propria.
C) A tumor with stage T3 has invaded the perirectal tissues.
D) A tumor that has metastasized to the lymph nodes would be given an N1 to N3 designation.
Page Ref: 99
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.D. Analyze colorectal cancer as it relates to cellular regulation. Describe the pathophysiology of colorectal cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with colorectal cancer.

9) A client with colorectal cancer has no metastasis in regional lymph nodes. Which outcome should the nurse conclude from this about metastasis of this cancer?
A) The distal lymph nodes and other major organs will also not have metastasis.
B) The tumor has instead metastasized to distal lymph nodes.
C) The nurse cannot conclude anything about metastasis to other areas of the body.
D) The tumor has instead metastasized through the circulatory system to other major organs.
Answer: C
Explanation: A) There is not enough information to determine that the distal lymph nodes and other major organs will not have metastasis.
B) A lack of metastasis does not mean that the tumor has metastasized to distal lymph nodes.
C) In some types of cancer, the regional lymph nodes are a good marker for metastasis. However, metastasis from colorectal cancer is not always an orderly process, and the absence or presence of metastasis in regional lymph nodes has no bearing on metastasis to distal lymph nodes or other major organs.
D) A lack of metastasis does not mean that the tumor has metastasized through the circulatory system to other major organs.
Page Ref: 99
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 2.D. Analyze colorectal cancer as it relates to cellular regulation. Describe the pathophysiology of colorectal cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with colorectal cancer.

10) The nurse is assessing a client. Which finding should the nurse report to the physician as a potential indication of colorectal cancer?
A) Abdominal pain
B) Constipation
C) Diarrhea
D) Rectal bleeding
Answer: D
Explanation: A) Abdominal pain can have many etiologies unrelated to colorectal cancer.
B) Constipation can have many etiologies unrelated to colorectal cancer.
C) Diarrhea can have many etiologies unrelated to colorectal cancer.
D) Rectal bleeding has fewer etiologies and should be assessed further for the potential cause.
Page Ref: 99
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.D. Analyze colorectal cancer as it relates to cellular regulation. Identify the clinical manifestations of colorectal cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with colorectal cancer.

11) The nurse is assessing several children with polyps in the colon and rectum. Which child is at highest risk of developing colorectal cancer in adulthood?

A) A 4-year-old with isolated juvenile polyps
B) A 6-month-old with diffuse juvenile polyposis of infancy
C) A 12-year-old with juvenile polyposis coli
D) A 7-year-old with adenomatous polyps

Answer: C

Explanation: A) Isolated juvenile polyps lack malignant potential.

B) Diffuse juvenile polyposis of infancy is almost always fatal, so the client is not likely to reach adulthood.

C) Children who develop juvenile polyposis or juvenile polyposis coli have an increased risk of developing colorectal cancer in adulthood by as much as 39%.

D) Adenomatous polyps also increase the risk for malignancy as adults, but this risk is not as high as 39%.

Page Ref: 101

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 2.D. Analyze colorectal cancer as it relates to cellular regulation. Differentiate considerations for care of patients with colorectal cancer across the lifespan.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with colorectal cancer.

12) The nurse is assessing an older adult client recently diagnosed with colorectal cancer. Which information should the nurse collect when completing the geriatric assessment?
A) The names, addresses, and birthdates of all of the client's children
B) The client's food diary for the past month
C) A complete list of all medications and supplements the client is currently taking
D) Whether the client has ever had a gastrointestinal disorder that caused diarrhea
Answer: C
Explanation: A) Although information related to social support is important, the nurse does not need the names, addresses, and birthdates of the client's children.
B) The client may not have a food diary for the past month unless specifically asked to record all food intake.
C) The geriatric assessment should evaluate the patient's functional status, physical performance, comorbidities, polypharmacy, nutritional status, cognitive function, emotional function, and social support. Asking for a complete list of all medications and supplements the client is currently taking will help assess polypharmacy.
D) A past history of gastrointestinal disorders is not as important as current comorbidities.
Page Ref: 103
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 2.D. Analyze colorectal cancer as it relates to cellular regulation. Differentiate considerations for care of patients with colorectal cancer across the lifespan.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with colorectal cancer.

Exemplar 2.E Leukemia

1) A client is receiving chemotherapy for acute lymphocytic leukemia. While providing care for this client, which clinical manifestations would indicate tumor lysis syndrome? **Select all that apply.**

A) Thrombocytopenia
B) Cardiac arrhythmia
C) Respiratory distress
D) Changes in urine output
E) Upper-extremity edema

Answer: B, D

Explanation: A) Thrombocytopenia occurs with a hematological emergency.

B) Tumor lysis causes a metabolic emergency. The release of intracellular contents into the circulation cause hyperkalemia, hyperuricemia, and hyperphosphatemia, which may lead to cardiac arrhythmias.

C) Space-occupying lesions can cause respiratory distress.

D) Tumor lysis causes a metabolic emergency. The release of intracellular contents into the circulation cause hyperkalemia, hyperuricemia, and hyperphosphatemia, which may lead to renal failure.

E) Space-occupying lesions can cause upper-extremity edema.

Page Ref: 115

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 2.E. Analyze leukemia as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with leukemia.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with leukemia.

2) An adult client reports an inability to tolerate usual exercise and the feeling of fatigue that has progressed over time. Which physical assessment findings, along with the client's verbal complaints, would indicate chronic lymphocytic leukemia (CLL)? **Select all that apply.**
A) Joint pain
B) Pallor
C) Splenomegaly
D) Abnormal bleeding
E) Edema
Answer: B, C, E
Explanation: A) Joint pain is a characteristic of acute myeloid leukemia (AML).
B) The symptoms for CLL are insidious and occur over time. The client may exhibit pallor.
C) The symptoms for CLL are insidious and occur over time. The client may exhibit splenomegaly.
D) Abnormal bleeding is a characteristic of acute myeloid leukemia (AML).
E) The symptoms for CLL are insidious and occur over time. The client may exhibit edema.
Page Ref: 108
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.E. Analyze leukemia as it relates to cellular regulation. Describe the pathophysiology of leukemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with leukemia.

3) The nurse is teaching a class about decreasing risk factors for cancer. Which risk factors should the nurse include in the teaching regarding leukemia? **Select all that apply.**
A) Smoking
B) Diets low in fat
C) Exposure to infectious agents
D) Bloom syndrome
E) Decreased exercise
Answer: A, C, D
Explanation: A) A higher incidence of leukemia is associated with cigarette smoking.
B) Low-fat diets are not a risk factor for leukemia.
C) A higher incidence of leukemia is associated with exposure to infectious agents.
D) A higher incidence of leukemia is associated with chromosomal defects such as Bloom syndrome.
E) Lack of exercise is not a risk factor for leukemia.
Page Ref: 110
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 2.E. Analyze leukemia as it relates to cellular regulation. Compare the risk factors for, and prevention of, leukemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with leukemia.

4) The nurse is planning care for a client with acute myeloid leukemia (AML). Which problems are priorities for this client to minimize the risk of complications associated with AML? **Select all that apply.**
A) Potential for infection
B) Heat intolerance
C) Weight loss
D) Excessive fluid volume
E) Potential for bleeding
Answer: A, E
Explanation: A) AML results in neutropenia (decreased neutrophils = risk of infection).
B) The client with AML does not have a problem with heat intolerance.
C) The client with AML does not have a problem with weight loss that would require nursing intervention.
D) The client with AML does not have a problem with fluid balance.
E) AML results in thrombocytopenia (decreased platelets, which leads to increased risk of bleeding).
Page Ref: 118
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 2.E. Analyze leukemia as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with leukemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with leukemia.

5) The interprofessional team is meeting to plan care for a school-age child with acute lymphocytic leukemia and the family. Which statement by the parents should receive priority in the nursing planning process?
A) "His brother is upset about the amount of time we are away from home."
B) "Can we plan a trip out of town sometime this summer?"
C) "We are afraid that he will dislodge his central line at school."
D) "How are we going to pay for his treatment?"
Answer: C
Explanation: A) The impact of the illness on the client's brother is a realistic concern, but not acute or life-threatening.
B) Questions about travel should be addressed, but they are not acute issues.
C) Dislodging the central line is an imminent, potentially life-threatening concern.
D) Financial worries, although a significant concern, would not take precedence over a potentially life-threatening concern.
Page Ref: 119
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: The role of family, culture, and community in a person's development. | Nursing Process: Planning
Learning Outcome: 2.E. Analyze leukemia as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with leukemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with leukemia.

6) The nurse is caring for a client with leukemia and thrombocytopenia. Which action will the nurse make a priority after the client has a bone marrow aspiration and biopsy?
A) Dispose of the equipment used and clean the area properly.
B) Label and refrigerate the specimen obtained by the physician.
C) Hold pressure on the wound for approximately 5 minutes.
D) Make certain the client understands the purpose of the test.
Answer: C
Explanation: A) Cleaning the area is completed after the client is stable and the specimen is sent to the laboratory.
B) Dealing with the specimen is accomplished by a third party or after the nurse stabilizes the client.
C) The most important task for the nurse is to prevent bleeding after the biopsy. Holding pressure on the wound for 5 minutes is effective.
D) An explanation of the test is performed before the procedure is begun.
Page Ref: 112
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 2.E. Analyze leukemia as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with leukemia.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with leukemia.

7) The nurse is caring for a client with leukemia who is experiencing neutropenia as a result of chemotherapy. Which action should the nurse include in the plan of care for this client?
A) Replace hand hygiene with gloves.
B) Restrict visitors with communicable illnesses.
C) Restrict fluid intake.
D) Insert an indwelling urinary catheter to prevent skin breakdown.
Answer: B
Explanation: A) Gloves may be appropriate but should never replace hand hygiene.
B) In the neutropenic client, visitors with communicable infections should be restricted.
C) Fluid intake should be encouraged.
D) Invasive procedures such as indwelling catheters should be avoided.
Page Ref: 119
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 2.E. Analyze leukemia as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with leukemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with leukemia.

8) The nurse is caring for a child with leukemia. Which type of leukemia is most common in children?
A) Chronic lymphocytic leukemia (CLL)
B) Acute lymphocytic (lymphoblastic) leukemia (ALL)
C) Acute myeloid (myeloblastic) leukemia (AML)
D) Chronic myeloid (myelogenous) leukemia (CML)
Answer: B
Explanation: A) CLL is more common in adults and is not common in children.
B) Acute lymphoblastic leukemia is the most common type of leukemia in children and adolescents.
C) AML is common in adults and is not common in children.
D) CML is common in adults and is not common in children.
Page Ref: 109
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.E. Analyze leukemia as it relates to cellular regulation. Differentiate considerations for care of patients with leukemia across the lifespan.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with leukemia.

9) The nurse is caring for a child with acute lymphoblastic leukemia (ALL). When providing education to the child's parents regarding this disease, which topics should the nurse include? **Select all that apply.**

A) ALL is characterized by abnormal proliferation of all bone marrow elements.
B) This form of leukemia is the most common type among children and adolescents.
C) Most cases of ALL result from a genetic alteration.
D) Malignant lymphocytes are able to effectively maintain immunity.
E) The onset of ALL is usually gradual.

Answer: B, C

Explanation: A) Chronic myeloid leukemia (CML) is characterized by abnormal proliferation of all bone marrow elements.
B) Acute lymphoblastic leukemia (ALL) is the most common type of leukemia among children and adolescents.
C) Most cases of ALL result from a genetic alteration.
D) Malignant lymphocytes are immature and do not function effectively to maintain immunity.
E) The onset of ALL is usually acute and rapid.

Page Ref: 109

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 2.E. Analyze leukemia as it relates to cellular regulation. Describe the pathophysiology of leukemia.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with leukemia.

10) The nurse is caring for a client with chronic myeloid leukemia (CML) who is neutropenic. Which interventions will the nurse implement to ensure this client's safety? **Select all that apply.**
A) Teach the client to maintain good personal hygiene.
B) Encourage the client to eat a diet low in protein.
C) Administer granulocyte colony-stimulating factor (G-CSF) as ordered.
D) Administer neutrophil colony-stimulating factor (N-CSF) as ordered.
E) Administer a prophylactic gram-negative antibiotic.
Answer: A, C
Explanation: A) A client who is neutropenic has a decrease in the level of white blood cells (WBCs) and is susceptible to infection and/or disease. To ensure the safety of the client with neutropenia, the nurse will teach the client to maintain good personal hygiene.
B) The client should be taught to eat a diet high in protein, not low in protein.
C) A client who is neutropenic has a decrease in the level of white blood cells (WBCs) and is susceptible to infection and/or disease. To ensure the safety of the client with neutropenia, the nurse will administer granulocyte colony-stimulating factor (G-CSF) as ordered.
D) The client will not receive neutrophil colony-stimulating factor (N-CSF).
E) Broad-spectrum antibiotics as ordered will be used.
Page Ref: 113
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 2.E. Analyze leukemia as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with leukemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with leukemia.

11) The nurse is planning care for a client with leukemia. Which actions will the nurse take to reduce this client's risk for bleeding? **Select all that apply.**
A) Educate client to not strain during bowel movements.
B) Use nonelectric razor when providing grooming for client.
C) Limit parenteral injections.
D) Apply pressure to arterial puncture sites for 5 minutes.
E) Encourage client to breathe deeply and huff cough frequently.
Answer: A, C
Explanation: A) The client at risk for bleeding has specific interventions to which the nurse should adhere. The nurse should educate the client to not strain during bowel movements.
B) The nurse should educate the client to use an electric razor to avoid bleeding.
C) The nurse should also limit the use of parenteral injections.
D) The nurse should apply 15 to 20 minutes of pressure to any arterial puncture sites.
E) The nurse should discourage the client from forceful coughing to prevent further bleeding.
Page Ref: 119
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 2.E. Analyze leukemia as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with leukemia.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with leukemia.

12) A client reports easily bruising, bleeding gums, and petechiae. Which complication of leukemia should the nurse consider the client is experiencing?

A) Thrombocytopenia
B) Anemia
C) Hepatomegaly
D) Neutropenia

Answer: A

Explanation: A) The manifestations of thrombocytopenia, a common complication of leukemia, include petechiae, purpura, ecchymoses, epistaxis, hematomas, hematuria, and gastrointestinal bleeding.

B) Anemia can be a late manifestation of thrombocytopenia.

C) Hepatomegaly is an enlarged liver.

D) Neutropenia increases the risk of infection in clients with leukemia.

Page Ref: 110

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies:AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 2.E. Analyze leukemia as it relates to cellular regulation. Identify the clinical manifestations of leukemia.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with leukemia.

Exemplar 2.F Lung Cancer

1) The nurse is caring for a client in a community clinic who wishes to quit smoking. The client asks the nurse, "If I quit smoking, will my risk of lung cancer be the same as a nonsmoker?" Which is the best response by the nurse?
A) "No one knows for sure what the risk is for someone who quits smoking."
B) "Your risk of lung cancer will be equal to that of a nonsmoker."
C) "Your risk of lung cancer will decline if you quit, but it will remain higher than a nonsmoker's."
D) "Your risk of lung cancer will never drop because the damage has already been done."
Answer: C
Explanation: A) The risk for someone who quits is known to be dramatically less than for someone who continues to smoke.
B) The risk for someone who quits is known to be dramatically less than for someone who continues to smoke.
C) While the client's risk for lung cancer will diminish sharply upon quitting smoking, it will not drop to the level of someone who never smoked.
D) The risk for someone who quits is known to be dramatically less than for someone who continues to smoke.
Page Ref: 123
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Implementation
Learning Outcome: 2.F. Analyze lung cancer as it relates to cellular regulation. Compare the risk factors for, and prevention of, lung cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with lung cancer.

2) The nurse is planning care to maintain the airway of a client with lung cancer. Which interventions should the nurse include in the client's plan of care? **Select all that apply.**
A) Suction the airway as needed.
B) Help the client turn, cough, and deep breathe as needed.
C) Provide chest percussion as ordered.
D) Educate the client about smoking cessation.
E) Administer pneumococcal vaccine.
Answer: A, B, C
Explanation: A) Suctioning can help clear secretions and improve airway clearance.
B) Turning, coughing, and deep breathing can help clear secretions and improve airway clearance.
C) Chest percussion can help clear secretions and improve airway clearance.
D) Educating the client on smoking cessation will not help maintain the client's airway.
E) Administering the pneumococcal vaccine will not help maintain the client's airway.
Page Ref: 129
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 2.F. Analyze lung cancer as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with lung cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with lung cancer.

3) The nurse is caring for a client recovering from a wedge resection of the left lung for a tumor. Which goals will the nurse identify to enhance this client's airway clearance? **Select all that apply.**

A) Minimize accumulation of fluid
B) Participation in care by the client
C) Maintain a patent airway
D) Maintain current weight
E) Express feelings and concerns

Answer: A, C

Explanation: A) An appropriate outcome to maintain airway clearance would be to minimize the accumulation of fluid.
B) Participating in care will not help with airway clearance.
C) An appropriate outcome to maintain airway clearance would be to maintain a patent airway.
D) Maintaining current weight will not help with airway clearance. All of the outcomes for this client are viable, but appropriate outcomes for the diagnosis of ineffective airway clearance are maintaining a patent airway and minimizing the accumulation of fluid.
E) Expressing feelings and concerns will not help with airway clearance.

Page Ref: 128
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | Nursing Process: Planning
Learning Outcome: 2.F. Analyze lung cancer as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with lung cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with lung cancer.

4) A client experiencing symptoms of lung cancer asks why a computed tomography (CT) scan was ordered. Which response will the nurse make?
A) "The doctor prefers this test."
B) "To rule out the possibility that your problems are caused by pneumonia."
C) "It is more specific in diagnosing your condition."
D) "Why are you concerned about this test?"
Answer: C
Explanation: A) A CT scan is not done because the healthcare provider prefers the test.
B) A chest x-ray can be used to diagnose pneumonia.
C) Computed tomography (CT) is used to evaluate and localize tumors, particularly tumors in the lung parenchyma and pleura. It also is done before needle biopsy to localize the tumor. In addition, CT scanning can detect distant tumor metastasis and evaluate tumor response to treatment.
D) The client's question is valid and should not be minimized by asking why the client is having concerns about the test.
Page Ref: 126
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 2.F. Analyze lung cancer as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with lung cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with lung cancer.

5) The nurse is reviewing the different types of lung cancer. Which type of lung cancer typically spreads by local invasion?
A) Small-cell carcinoma
B) Adenocarcinoma
C) Squamous cell carcinoma
D) Large-cell carcinoma
Answer: C
Explanation: A) Small-cell carcinoma has distant metastasis early in the course of the disease.
B) Adenocarcinoma has distant metastasis early in the course of the disease.
C) Squamous cell carcinoma tends to spread by local invasion.
D) Large-cell carcinoma has distant metastasis early in the course of the disease.
Page Ref: 122
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.F. Analyze lung cancer as it relates to cellular regulation. Describe the pathophysiology of lung cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with lung cancer.

6) The nurse is preparing a teaching tool about lung cancer. Which individuals are more likely to develop lung cancer without a history of smoking?
A) An individual under age 50
B) An individual with a genetic abnormality on chromosome 6
C) An individual over age 50
D) An individual with a genetic abnormality on chromosome 8
Answer: B
Explanation: A) Although incidence does increase with age, age is not a risk factor for lung cancer in nonsmokers.
B) Individuals with a genetic abnormality on chromosome 6 are more likely to develop lung cancer regardless of their smoking history.
C) Although incidence does increase with age, age is not a risk factor for lung cancer in nonsmokers.
D) Individuals with a genetic abnormality on chromosome 6, not chromosome 8, are more likely to develop lung cancer regardless of their smoking history.
Page Ref: 122
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.F. Analyze lung cancer as it relates to cellular regulation. Describe the etiology of lung cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with lung cancer.

7) A client with lung cancer is experiencing dysphagia. Which location should the nurse suspect is the location of this client's tumor?
A) By the trachea
B) By the esophagus
C) By the mediastinum
D) By the pleura
Answer: B
Explanation: A) Hoarseness indicates pressure on the trachea.
B) Signs and symptoms can provide an indication of the location of the tumor associated with lung cancer. Dysphagia indicates pressure on the esophagus.
C) Dull, aching chest pain occurs as the tumor spreads to the mediastinum.
D) Pleuritic pain occurs when the pleura is invaded.
Page Ref: 123
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies:AACN Domains and Competencies: 2.3 Integrate assessment skills in practice | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.F. Analyze lung cancer as it relates to cellular regulation. Identify the clinical manifestations of lung cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with lung cancer.

8) The nurse is caring for a 72-year-old client who was just diagnosed with early-stage lung cancer. Which independent nursing intervention can improve the client's prognosis?
A) Provide client teaching related to a nutritional diet
B) Refer the client to a smoking cessation therapy group
C) Advocate for an immediate initiation of treatment
D) Encourage the client to form a strong support group
Answer: C
Explanation: A) A nutritional diet could also be helpful, but it likely will not affect the prognosis significantly.
B) A smoking cessation therapy group could be helpful, but at this client's age and recent diagnosis, a therapy group is not as important as initiating treatment.
C) Studies have indicated that delays in the time from diagnosis to initiation of treatment may affect the patient's prognosis in older adults. Delays in diagnosis and treatment should be avoided to prevent the risk of disease progression.
D) Support groups can provide emotional support to the client, but this will not improve the client's prognosis as much as early treatment.
Page Ref: 128
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.9 Provide care coordination. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 2.F. Analyze lung cancer as it relates to cellular regulation. Differentiate considerations for care of patients with lung cancer across the lifespan.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with lung cancer.

WwW.TeSt.Wo

9) The nurse is providing discharge teaching to an older adult client with lung cancer. Which changes in activities of daily living can the nurse suggest to help the older adult maintain independence?
A) Wear shirts with buttons
B) Use a self-leveling spoon
C) Wear shoes with laces
D) Use a shower chair
Answer: D
Explanation: A) Wearing slip-on shirts, not shirts with buttons, can help conserve energy.
B) Self-leveling spoons are important for individuals who have hand tremors; they do not help conserve energy when feeding.
C) Wearing slip-on shoes, not shoes with laces, can help conserve energy.
D) Lung cancer reduces the amount of functional lung tissue, leading to activity intolerance when oxygen supply is insufficient. The nurse should teach the client ways to conserve energy, such as sitting on a shower chair while showering.
Page Ref: 129
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 2.F. Analyze lung cancer as it relates to cellular regulation. Differentiate considerations for care of patients with lung cancer across the lifespan.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with lung cancer.

WwW.TeSm.Ws

Exemplar 2.G Prostate Cancer

1) A nurse is screening a client for prostate cancer. Which assessment findings would cause the nurse to suspect that the client has prostate cancer? **Select all that apply.**
A) Fatigue
B) Upper extremity weakness
C) Back pain
D) Hematuria
E) Scrotal edema
Answer: A, C, D
Explanation: A) Fatigue is a symptom of prostate cancer.
B) Upper extremity weakness is not a symptom of prostate cancer.
C) Back pain is a symptom of prostate cancer.
D) Hematuria is a symptom of prostate cancer.
E) Scrotal edema is not a symptom of prostate cancer.
Page Ref: 133
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.G. Analyze prostate cancer as it relates to cellular regulation. Identify the clinical manifestations of prostate cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with prostate cancer.

2) The nurse is preparing an educational program on risk factors for the development of prostate cancer. Which information will the nurse include as being the greatest risk factor for developing prostate cancer?
A) The client's age
B) A family history
C) A history of a vasectomy
D) A diet high in fat
Answer: A
Explanation: A) The greatest risk for developing prostate cancer is age.
B) A family history is another risk factor but is not the greatest risk factor.
C) Having had a vasectomy increases the risk but is not the greatest risk factor.
D) A high fat diet is a risk factor but is not the greatest risk factor.
Page Ref: 132
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Implementation
Learning Outcome: 2.G. Analyze prostate cancer as it relates to cellular regulation. Compare the risk factors for, and prevention of, prostate cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with prostate cancer.

3) While receiving discharge teaching, an adult client recovering from a prostatectomy is distressed to learn that episodes of incontinence may occur. Which should the nurse teach the client to help minimize incontinence?
A) Proper administration of incontinence medication
B) Steps to change the indwelling catheter bag every day
C) Fluid restriction
D) Kegel exercises
Answer: D
Explanation: A) Medication is not an appropriate long-term treatment for this complication.
B) An indwelling catheter is not an appropriate long-term treatment for this complication.
C) Restricting fluids may cause further urinary problems and is not advised.
D) Urinary incontinence after surgery is not unexpected. Teaching the client Kegel exercises is the best way to help eliminate or reduce occasions of stress incontinence.
Page Ref: 138
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 2.G. Analyze prostate cancer as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with prostate cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with prostate cancer.

4) A client having a prostatectomy asks if there will be any limitations after the surgery. Which complications is the client likely to have that should be incorporated into the plan of care? **Select all that apply.**
A) Constipation
B) Gynecomastia
C) Urinary stress incontinence
D) Risk for falls
E) Sexual dysfunction
Answer: C, E
Explanation: A) There is no reason to suspect that this client is at risk for constipation.
B) Gynecomastia is a side effect of treatment with estrogen compounds, not surgery.
C) Following a prostatectomy, the client is most at risk for urinary stress incontinence.
D) There is no reason to suspect that this client is at risk for falls.
E) Following a prostatectomy, the client is most at risk for sexual dysfunction.
Page Ref: 134
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 2.G. Analyze prostate cancer as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with prostate cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with prostate cancer.

5) The nurse is asked to explain which clients are at risk for prostate cancer. Which response will the nurse make?
A) "African American men are at lowest risk for prostate cancer."
B) "Asian American and Native American men have the highest risk for developing prostate cancer."
C) "Approximately one in twelve men ages 70 and older will be diagnosed with prostate cancer."
D) "A diet low in dairy increases a man's risk for developing prostate cancer."
Answer: C
Explanation: A) African Americans are at a particularly high risk for developing prostate cancer.
B) African Americans are at a particularly high risk for developing prostate cancer.
C) Approximately one in twelve men ages 70 and older will be diagnosed with prostate cancer.
D) A diet high in dairy increases a man's risk for developing prostate cancer.
Page Ref: 132
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 2.G. Analyze prostate cancer as it relates to cellular regulation. Compare the risk factors for, and prevention of, prostate cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with prostate cancer.

6) The nurse is assessing a client for symptoms of prostate cancer. Which symptoms would indicate the client is experiencing an enlarged prostate? **Select all that apply.**
A) Hematuria
B) Dysuria
C) Weight loss
D) Bone pain
E) Fatigue
Answer: A, B
Explanation: A) Symptoms of an enlarged prostate includes hematuria.
B) Symptoms of an enlarged prostate includes dysuria.
C) Weight loss is a symptom of metastasis.
D) Bone pain is a symptom of metastasis.
E) Fatigue is a symptom of metabolic changes.
Page Ref: 133
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.G. Analyze prostate cancer as it relates to cellular regulation. Identify the clinical manifestations of prostate cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with prostate cancer.

7) A client with prostate cancer is being discharged from the hospital. Which educational topic is least appropriate for this client?
A) Provide information on doses of complementary herbs.
B) Teach the client and his family methods of pain control.
C) Stress the importance of keeping client appointments with healthcare providers.
D) Provide the client and the client's family information on support groups.
Answer: A
Explanation: A) The nurse does not have authorization to provide information on doses of complementary herbs.
B) When providing discharge instructions to the client with prostate cancer, the nurse will teach the client and family methods of pain control.
C) When providing discharge instructions to the client with prostate cancer, the nurse will stress the importance of keeping client appointments with healthcare providers.
D) The nurse will provide the client and family information on support groups.
Page Ref: 138
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 2.G. Analyze prostate cancer as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with prostate cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with prostate cancer.

8) The nurse is reviewing the pathophysiology of prostate cancer. Which hormones are believed to have a role in the development of prostate cancer?
A) Prolactin
B) Endorphins
C) Estrogens
D) Androgens
Answer: D
Explanation: A) Prolactin has not been linked to the development of prostate cancer.
B) Endorphins have not been linked to the development of prostate cancer.
C) Estrogens have not been linked to the development of prostate cancer.
D) Androgens are hormones synthesized in the testes and adrenal cortex in males that promote expression of male sex characteristics. They are believed to have a role in the development of prostate cancer.
Page Ref: 132
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.G. Analyze prostate cancer as it relates to cellular regulation. Describe the pathophysiology of prostate cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with prostate cancer.

9) The nurse is reviewing the potential for metastasis from prostate cancer. For which reason is it rare for this type of cancer to metastasize to the bowel?
A) The capsular artery supplies blood to the bowel before the prostate.
B) The inferior vesical artery supplies blood to the bowel before the prostate.
C) The rectourethral fistula acts as a physical barrier to metastasis.
D) The rectoprostatic fascia acts as a physical barrier to metastasis.
Answer: D
Explanation: A) The capsular artery provides blood to the prostate but not the bowel.
B) The inferior vesical artery provides blood to the prostate but not the bowel.
C) A rectourethral fistula may develop as a result of treatment for prostate cancer.
D) Despite its proximity to the rectum, metastasis to the bowel is uncommon in prostate cancer, because a tough sheet of tissue, the rectoprostatic fascia, acts as an effective physical barrier between the bowel and prostate.
Page Ref: 132
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.G. Analyze prostate cancer as it relates to cellular regulation. Describe the pathophysiology of prostate cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with prostate cancer.

10) The nurse is reviewing laboratory values for a client being tested for prostate cancer. Which approach is appropriate for interpreting the prostate-specific antigen (PSA) level?
A) A PSA level higher than 4.0 ng/mL indicates prostate cancer.
B) A PSA level lower than 4.0 ng/mL indicates prostate cancer.
C) A fluctuating PSA level indicates prostate cancer.
D) An abnormal PSA level alone is not enough to diagnose prostate cancer.
Answer: D
Explanation: A) The National Cancer Institute used to consider a PSA level of 4.0 ng/mL or lower to be normal, but men with normal PSA levels may still have prostate cancer.
B) The National Cancer Institute used to consider a PSA level of 4.0 ng/mL or lower to be normal, but men with normal PSA levels may still have prostate cancer.
C) PSA levels that fluctuate could be an indication of prostate cancer, but it could also indicate prostatitis or urinary tract infection.
D) PSA levels must be interpreted in conjunction with the patient's health history and other diagnostic tests to confirm a diagnosis of prostate cancer.
Page Ref: 133
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Integration of knowledge from nursing and other disciplines. | Nursing Process: Assessment
Learning Outcome: 2.G. Analyze prostate cancer as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with prostate cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with prostate cancer.

11) A 42-year-old male client was recently diagnosed with prostate cancer. Which characteristic of this disease does the nurse need to be aware of for a client of this age compared to older men with prostate cancer?

A) The cancer will likely be more aggressive for the younger client.
B) The cancer will likely grow more slowly in the younger client.
C) The cancer will likely be more responsive to treatment in the younger client.
D) The cancer will likely not metastasize as quickly in the younger client.

Answer: A

Explanation: A) Research has found that prostate cancers that are diagnosed at a younger age tend to be more aggressive.

B) Evidence has not yet shown whether prostate cancer grows more slowly in younger clients.

C) Evidence has not yet shown whether prostate cancer responds to treatment better in younger clients.

D) Research has found that metastasis may have already occurred, given the advanced disease state at the time of diagnosis.

Page Ref: 137

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 2.G. Analyze prostate cancer as it relates to cellular regulation. Differentiate considerations for care of patients with prostate cancer across the lifespan.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with prostate cancer.

12) The spouse of an older client cries and asks how long the client has to live after being diagnosed with prostate cancer. Which response by the nurse is appropriate?
A) "Don't worry about how long he will live. Just live every day to the fullest and enjoy the time you have left together."
B) "If we treat the cancer aggressively with surgery and radiation, he should live several more years."
C) "Prostate cancer is usually aggressive in older men, so he may only have a short time to live."
D) "Older men who are diagnosed with prostate cancer usually die from causes other than the cancer."
Answer: D
Explanation: A) The nurse should not dismiss the client's or client's family's concerns by telling them to not worry.
B) Early-stage prostate cancer in older men may not be treated aggressively. Instead, the healthcare team may take a more conservative "watchful waiting" approach, depending on other health conditions.
C) The nurse cannot predict how long the client may live after diagnosis. Prostate cancer is usually aggressive in younger men, not older men.
D) In an older man with a lower stage of cancer at diagnosis, the cancer is likely slow-growing, and he is more likely to die from other preexisting comorbidities than from the cancer itself.
Page Ref: 137
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 2.G. Analyze prostate cancer as it relates to cellular regulation. Differentiate considerations for care of patients with prostate cancer across the lifespan.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with prostate cancer.

Exemplar 2.H Sickle Cell Disease

1) Parents of a newborn infant are concerned that their baby may have sickle cell disease since both parents have the sickle cell trait. Which response should the nurse make to the parents?

A) "Since neither of you actually has sickle cell disease, your baby is not at risk."

B) "Your baby has the disease, as you both carry the trait."

C) "We are required to test all babies for sickle cell disease."

D) "Have you talked to a genetic counselor about your concerns?"

Answer: C

Explanation: A) Because both parents only have the sickle cell trait, the baby has a 25% chance of having sickle cell disease.

B) The nurse can assure the parents that the baby will be tested so they know for sure if the baby has sickle cell disease.

C) In the United States, newborn screening for sickle cell disease is mandatory.

D) A genetic counselor is not needed at this time.

Page Ref: 144

Cognitive Level: Applying

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 2.H. Analyze sickle cell disease as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with sickle cell disease.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with sickle cell disease.

2) The nurse is teaching a group of parents how to prevent a sickle cell crisis in the child with sickle cell disease. Which precipitating factors that could contribute to a sickle cell crisis should the nurse teach the parents? **Select all that apply.**
A) Increased fluid intake
B) High altitudes
C) Fever and infection
D) Emotional or physical stress
E) Warm temperatures
Answer: B, C, D
Explanation: A) Increased fluid intake is recommended for a child with sickle cell disease and will not contribute to a sickle cell crisis.
B) High altitude is a precipitating factor that contributes to a sickle cell crisis.
C) Fever and infection increases the risk for a sickle cell crisis.
D) Emotional or physical stress increase the risk for a sickle cell crisis.
E) Cold temperatures, not warm temperatures, are a trigger for sickle cell crisis.
Page Ref: 142, 146
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 2.H. Analyze sickle cell disease as it relates to cellular regulation. Describe the etiology of sickle cell disease.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with sickle cell disease.

3) The nurse is assigned to care for a client with sickle cell disease who is being admitted with splenic sequestration crisis. Which room would be the most appropriate for this client?
A) Private room
B) Semi-private room
C) Contact-isolation room
D) Airborne-isolation room
Answer: A
Explanation: A) Splenic sequestration can be life-threatening, and there is profound anemia. The client should not be placed in a room with any other client who might have an infectious illness.
B) The client should not be placed in a room with any other client who might have an infectious illness, so a semi-private room is not appropriate.
C) The client is not contagious; therefore, contact isolation is not required.
D) The client is not contagious; therefore, an airborne isolation room is not necessary.
Page Ref: 143
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 2.H. Analyze sickle cell disease as it relates to cellular regulation. Describe the pathophysiology of sickle cell disease.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with sickle cell disease.

4) A client in sickle cell crisis reports a pain level of 8 on a pain scale from 1 to 10. Which problem is a priority for this client?
A) Excessive body fluids
B) Risk for self-harm
C) Lack of understanding about the crisis
D) Experiencing pain
Answer: D
Explanation: A) There is no evidence from the information given that the client has fluid volume excess.
B) There is no evidence from the information given that the client is at risk for self-harm.
C) This client appears to have a knowledge deficit about self-care.
D) The priority for this client would be pain.
Page Ref: 143
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 2.H. Analyze sickle cell disease as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with sickle cell disease.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with sickle cell disease.

5) A client in sickle cell crisis has a temperature of 102°F, O_2 saturation of 89%, and complaints of severe abdominal pain. Based on the assessment findings, which intervention is the greatest priority?
A) Apply oxygen per nasal cannula at 3 L/minute.
B) Assess and document peripheral pulses.
C) Administer morphine sulfate 10 mg IM.
D) Administer Tylenol 650 mg by mouth.
Answer: A
Explanation: A) Hypoxia is often the cause of a sickle cell crisis from the clumping of damaged RBCs, which creates an obstruction and hypoxia distal to the clumping. Administering the oxygen will improve the pain and increase the oxygen saturation of body tissues.
B) Full body assessment, including peripheral pulses, is significant to identify the location of the potential obstruction, but this is secondary to treating the hypoxia that is known to be present from the sickling of the cells during sickle cell crisis.
C) Morphine sulfate is a narcotic for pain, but it should be given after the oxygen is started, since the symptoms are caused by hypoxia. The morphine will decrease the pain and decrease metabolic oxygen needs by decreasing basal metabolic rates; therefore, supply is increased and demand is increased.
D) Tylenol is not the first action the nurse should take, because a sickle cell crisis is caused by oxygen deprivation in tissues, not by the fever.
Page Ref: 148
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies:AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 2.H. Analyze sickle cell disease as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with sickle cell disease.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with sickle cell disease.

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6) The nurse is planning care for a young child with sickle cell crisis whose parents have limited information about the disease. When planning care for this family, the nurse will set which goal with this family?
A) The child will drink adequate amounts of fluid each day.
B) The child will play outside in the sun.
C) The family will not have the child vaccinated.
D) The family will plan vacations in high-altitude areas.
Answer: A
Explanation: A) For the client with sickle cell disease, dehydration can lead to life-threatening consequences. The client's oral intake should be adjusted as necessary to keep the child well hydrated. Teach clients and parents how to monitor intake and output and provide client teaching regarding fluid management.
B) Playing outdoors in the sun can lead to dehydration, which can precipitate a crisis.
C) Infection and illnesses with fever will increase the body's demand for oxygen, so it is important for the family to keep up with the child's immunization schedule.
D) Oxygen supply at high altitudes is too low for the client with sickle cell disease.
Page Ref: 148
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 2.H. Analyze sickle cell disease as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with sickle cell disease.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with sickle cell disease.

7) The nurse is caring for a client who was admitted to a medical-surgical unit in sickle cell crisis. Which medication should the nurse expect to administer to this client?
A) Acetaminophen (Tylenol)
B) Ibuprofen (Advil)
C) Meperidine (Demerol)
D) Hydroxyurea
Answer: D
Explanation: A) Acetaminophen is used for mild pain but would not be effective for the severe pain experienced by a client in sickle cell pain crisis.
B) Ibuprofen is used for mild pain, but would not be effective for the severe pain experienced by a client in sickle cell pain crisis.
C) Meperidine is not used for pain control for clients in sickle cell crisis because it can cause seizures.
D) Hydroxyurea decreases production of abnormal blood cells and leads to a lesser amount of pain being experienced.
Page Ref: 143
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 2.H. Analyze sickle cell disease as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with sickle cell disease.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with sickle cell disease.

8) A 3-year-old client receiving treatment for sickle cell disease is at risk for infection. Which medication does the nurse expect to administer to this client?

A) Acetaminophen
B) Penicillin
C) Morphine sulfate
D) Tamoxifen

Answer: B

Explanation: A) Acetaminophen may be given for the pain the client experiences during a sickle cell crisis.

B) Prophylactic penicillin is often prescribed to children between the ages of 2 months and 5 years of age who are diagnosed with sickle cell disease because of the increased risk for infection.

C) Morphine may be given for the pain the client experiences during a sickle cell crisis.

D) Tamoxifen is a medication used to treat breast cancer.

Page Ref: 144

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 2.H. Analyze sickle cell disease as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with sickle cell disease.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with sickle cell disease.

9) The nurse is educating the client with sickle cell disease and the family regarding the genetic implications of the disease. Which information is inappropriate for the nurse to share with the client's family?
A) If both parents have the trait, then with each pregnancy, the risk of having a child with the disease is 50%.
B) The disorder is transmitted as an autosomal recessive genetic defect.
C) The sickle cell gene may have originated to protect against lethal forms of malaria.
D) In African Americans, sickle cell disease occurs in 1 of every 365 births.
Answer: A
Explanation: A) If both parents have the trait, then with each pregnancy, the risk of having a child with the disease is 25%, not 50%.
B) In educating the client and the client's parents regarding sickle cell disease, the nurse will state that the disorder is transmitted as an autosomal recessive genetic defect.
C) The sickle cell gene may have originated to protect against lethal forms of malaria.
D) In African Americans, sickle cell disease occurs in 1 of every 365 births.
Page Ref: 141
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 2.H. Analyze sickle cell disease as it relates to cellular regulation. Describe the etiology of sickle cell disease.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with sickle cell disease.

10) An emergency department nurse is caring for a child in sickle cell crisis. The nurse suspects the etiology of the crisis as being thrombotic in nature because of which clinical manifestations? **Select all that apply.**

A) The client has profound pallor and fatigue.
B) The client is in extreme pain.
C) The client has profound hypotension and shock.
D) The client has a fever.
E) The client's chest CT reveals a pulmonary infarct.

Answer: B, D

Explanation: A) The client with profound pallor and fatigue likely is in an aplastic crisis, not thrombosis.
B) A thrombotic sickle cell crisis is manifested by extreme pain.
C) The client in profound hypotension and shock likely has splenic sequestration as the etiology, not thrombosis.
D) A thrombotic sickle cell crisis is manifested by fever.
E) The client with a pulmonary infarct likely has acute chest syndrome, not thrombosis.

Page Ref: 142
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.H. Analyze sickle cell disease as it relates to cellular regulation. Identify the clinical manifestations of sickle cell disease.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with sickle cell disease.

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11) A client with sickle cell disease is experiencing extreme pain. Which intervention is inappropriate for the nurse to include in this plan of care?
A) Administer prescribed analgesic medications around the clock.
B) Place client in a position of comfort.
C) Use heat or cold packs as tolerated.
D) Support the client's joints and extremities with pillows.
Answer: C
Explanation: A) The client with sickle cell disease who is in a sickle cell crisis will likely have extreme pain. To aid in caring for this client, the nurse will administer prescribed analgesic medications around the clock.
B) To aid in caring for this client, the nurse will place the patient in a position of comfort.
C) The use of heat or cold packs is contraindicated in the sickle cell client.
D) To aid in caring for this client, the nurse will support the client's joints and extremities with pillows.
Page Ref: 148
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 2.H. Analyze sickle cell disease as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with sickle cell disease.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with sickle cell disease.

12) The nurse is reviewing risk factors for the development of sickle cell disease. Which race is at highest risk of inheriting sickle cell disease?
A) African American
B) Caucasian
C) Hispanic
D) Asian
Answer: A
Explanation: A) Sickle cell disease is most common among people of African descent. An estimated 1 in 13 African Americans carries one abnormal hemoglobin gene, and 1 in 365 African American newborns are born with two Hb S genes.
B) Sickle cell disease is not common in the Caucasian race.
C) Sickle cell disease is not common in Hispanics.
D) Sickle cell disease is not common in Asians.
Page Ref: 141
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment
Learning Outcome: 2.H. Analyze sickle cell disease as it relates to cellular regulation. Compare the risk factors for, and prevention of, sickle cell disease.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with sickle cell disease.

Exemplar 2.I Skin Cancer

1) During a routine physical examination of a client's lungs, the nurse notes a pink papule that is flat and erythematous with surface crusting on the client's upper chest. For which potential skin disorder will the nurse notify the healthcare provider of this finding?
A) Squamous cell carcinoma
B) Basal cell carcinoma
C) Actinic keratosis
D) Malignant melanoma
Answer: B
Explanation: A) Squamous cell carcinoma is most often found on parts that are exposed to the sun, such as the face and hands. It usually appears as a small, firm, red nodule that may bleed as it grows.
B) Superficial basal cell carcinoma is often found on the trunk, and it manifests as a papule or plaque that is flat, pink, erythematous, and crusting.
C) Actinic keratosis is a precancerous condition. The lesion appears as a shiny, rough macule.
D) Malignant melanoma manifests as black, brown, or multicolored nodules or plaques.
Page Ref: 152
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.I. Analyze skin cancer as it relates to cellular regulation. Identify the clinical manifestations of skin cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with skin cancer.

2) The nurse is teaching a group of community members about preventing skin cancer. Which participant would be at the greatest risk for skin cancer?
A) A 25-year-old lifeguard at the community pool who wears sunscreen
B) A baby underneath a large beach umbrella
C) A 60-year-old farmer who wears a cap when working
D) A teenager who wears a ski outfit when skiing
Answer: C
Explanation: A) The lifeguard has lesser risk because of using sunscreen.
B) The baby is at less risk because of being under an umbrella.
C) The older adult client has had more years of living to increase the risk of skin cancer from exposure to the sun. In addition, the farmer wears a cap, but no mention is made of protectant sunscreens or long-sleeved shirts and pants.
D) The teenager has less risk because of wearing a ski outfit when skiing.
Page Ref: 153
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.I. Analyze skin cancer as it relates to cellular regulation. Compare the risk factors for, and prevention of, skin cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with skin cancer.

3) The nurse learns that a client with olive skin plans to "get a tan" when on vacation. Which statement indicates that additional teaching about sun exposure is needed?
A) "I don't need sunscreen because I have darker skin already."
B) "I will avoid the sun between the peak hours of 10 AM and 4 PM."
C) "I can still experience sun damage despite my darker skin tones."
D) "The melanocytes in my skin provide me with increased protection from the sun."
Answer: A
Explanation: A) While the melanocytes in darker skin offer increased protection, the risk for skin cancer remains and sunscreen should be worn.
B) Sun should be avoided between the peak hours of 10 AM and 4 PM.
C) While the melanocytes in darker skin offer increased protection, sun damage can still occur.
D) The melanocytes in darker skin do provide increased protection from the sun.
Page Ref: 154
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 2.I. Analyze skin cancer as it relates to cellular regulation. Compare the risk factors for, and prevention of, skin cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with skin cancer.

4) The nurse is caring for an older adolescent client diagnosed with malignant melanoma. Which problems would be appropriate when planning this client's care? **Select all that apply.**
A) Anxiety
B) Impaired skin integrity
C) Imbalance in body fluids
D) Problems with peer group
E) Questions about missing school
Answer: A, B
Explanation: A) Any client will likely experience anxiety related to the diagnosis of skin cancer.
B) Any client will likely experience impaired skin integrity related to the diagnosis of skin cancer.
C) There is no evidence that the client has an imbalance in body fluids.
D) There is no evidence that the client has problems with the peer group.
E) There is no evidence that the client is going to miss school.
Page Ref: 160
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 2.I. Analyze skin cancer as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with skin cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with skin cancer.

5) During a community health fair, a young client asks about the safety of tanning beds. Which response should the nurse make?
A) "Using tanning beds without clothing contaminates skin and leads to infections."
B) "Tanning from ultraviolet light is safer than sunshine."
C) "Using sunscreen will prevent skin cancers, even in tanning beds."
D) "Exposure to ultraviolet light used in tanning beds can cause skin cancer."
Answer: D
Explanation: A) That using tanning beds without clothing causes infection may or may not be true, depending on the disinfecting methods used.
B) Direct sunlight and tanning beds both emit ultraviolet light that can cause skin damage that leads to skin cancer.
C) The use of sunscreen can reduce the risk of cancer but not prevent it, especially in tanning beds where the ultraviolet light is intensified.
D) Ultraviolet light exposure greatly increases risk of skin cancer, both basal cell and melanoma types.
Page Ref: 154
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 2.I. Analyze skin cancer as it relates to cellular regulation. Compare the risk factors for, and prevention of, skin cancer.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with skin cancer.

6) A client is scheduled to have a suspected cancerous lesion removed from the arm. When planning care for this client, which outcome would be a priority?
A) The client will make nutritional changes.
B) The client will experience minimal pain after healing.
C) The client will heal without signs of infection.
D) The client will not need to make lifestyle changes.
Answer: C
Explanation: A) Nutritional changes may or may not be needed; however, prevention of infection is the priority.
B) The client should not experience pain after healing.
C) Following removal of a skin lesion, the nurse directs care aimed at the prevention of infection while the skin heals.
D) The client will need to make lifestyle changes to prevent further occurrences of skin cancer.
Page Ref: 160
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 2.I. Analyze skin cancer as it relates to cellular regulation. Apply the nursing process in providing culturally competent care to an individual with skin cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with skin cancer.

7) The nurse is reviewing the medical records for several clients who will be seen in the clinic today. According to the ABCDE rule, which client may require removal of the skin lesion?
A) A client with a lesion that is symmetrical with an irregular border, a single color, and diameter change from 4 mm to 5 mm
B) A client with a lesion that is symmetrical, with a smooth border, a single color, and diameter that has stayed the same
C) A client with a lesion that is asymmetrical with a regular border, two colors, and diameter change from 4 mm to 3 mm
D) A client with a lesion that is asymmetrical with an irregular border, two colors, and diameter change from 5 mm to 7 mm
Answer: D
Explanation: A) To meet all four criteria for removal of a lesion, the lesion will be asymmetrical, have irregular borders, show color change or more than one color, and have a diameter greater than 6 mm. This client's lesion does not meet the ABCDE criteria.
B) To meet all four criteria for removal of a lesion, the lesion will be asymmetrical, have irregular borders, show color change or more than one color, and have a diameter greater than 6 mm. This client's lesion is not considered a potential pathologic problem.
C) To meet all four criteria for removal of a lesion, the lesion will be asymmetrical, have irregular borders, show color change or more than one color, and have a diameter greater than 6 mm. This client's lesion does not require removal according to the ABCDE rule.
D) To meet all four criteria for removal of a lesion, the lesion will be asymmetrical, have irregular borders, show color change or more than one color, and have a diameter greater than 6 mm.
Page Ref: 157

Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.I. Analyze skin cancer as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with skin cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with skin cancer.

8) A client diagnosed with skin cancer asks how it occurred when no time is spent tanning. Which response should the nurse make?
A) "Can you tell me more about your feelings?"
B) "This is unusual, as skin cancer normally only occurs in sunbathers."
C) "Sun exposure can happen as we carry out our daily activities."
D) "We frequently never find out why cancer strikes."
Answer: C
Explanation: A) The client is seeking information. The nurse does not need to ask the client to explain feelings.
B) Skin cancer can develop in anyone with any amount of sun exposure.
C) Sun exposure occurs as we carry out our daily activities, such as riding in the car, going in and out of buildings, and playing or working outside.
D) The number one risk for skin cancer is sun exposure.
Page Ref: 154
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 2.I. Analyze skin cancer as it relates to cellular regulation. Compare the risk factors for, and prevention of, skin cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with skin cancer.

9) The nurse is caring for a client who has been diagnosed with a lentigo maligna. Which statement is inappropriate for the nurse to include in the client's teaching plan?
A) The lesion is also called Robertson freckle.
B) The lesion is a precursor to melanoma.
C) The lesion is a tan or black patch on the skin that looks like a freckle.
D) The lesion grows slowly, becoming mottled, dark, thick, and nodular.
Answer: A
Explanation: A) A lentigo maligna, also called a Hutchinson freckle, is a precursor to melanoma.
B) A lentigo maligna is a precursor to melanoma.
C) The lesion is a tan or black patch on the skin that looks like a freckle.
D) The lesion grows slowly, and becomes mottled, dark, thick, and nodular.
Page Ref: 155
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 2.I. Analyze skin cancer as it relates to cellular regulation. Describe the pathophysiology of skin cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with skin cancer.

10) The nurse is using the ABCDE rule to evaluate a client's skin lesions. Which should the nurse evaluate for the letter "D"?
A) Diameter of lesion greater than 8 mm
B) Distance of lesion to an additional lesion
C) Diameter of lesion greater than 6 mm
D) Depth of lesion
Answer: C
Explanation: A) The ABCDE rule is used to assess suspicious lesions. The "D" is the diameter of the lesion greater than 6 mm.
B) The ABCDE rule is used to assess suspicious lesions. The D does not measure the distance of a lesion to another lesion.
C) The ABCDE rule is used to assess suspicious lesions, The "D" is the diameter of the lesion is greater than 6 mm.
D) The ABCDE rule is used to assess suspicious lesions. The "D" does not measure the depth of the lesion.
Page Ref: 156
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 2.I. Analyze skin cancer as it relates to cellular regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with skin cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with skin cancer.

11) The nurse is planning a teaching tool about skin cancer. Which cause of skin cancer should the nurse identify as being the most common?
A) Exposure to melanin
B) UV radiation from sunlight
C) Damage from chemicals
D) Inflammation from psoriasis
Answer: B
Explanation: A) Melanin is a naturally-occurring skin pigment. Exposure to melanin itself does not cause skin cancer.
B) Exposure to UV radiation from sunlight is a major cause of skin cancer. Tanning beds are another dangerous form of UV exposure.
C) Although damage from chemicals may lead to skin cancer, it is not a common cause of skin cancer.
D) Inflammation from psoriasis is not directly linked to skin cancer.
Page Ref: 153
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Planning
Learning Outcome: 2.I. Analyze skin cancer as it relates to cellular regulation. Describe the etiology of skin cancer.
MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with skin cancer.

12) An older client is diagnosed with skin cancer. Which assessment should the nurse complete before implementing a topical medication?

A) Coagulation disorders
B) Dementia
C) Cardiovascular disease
D) Diabetes

Answer: B

Explanation: A) Coagulation disorders should be considered before planning surgical interventions for older clients with skin cancer.

B) For older clients with skin cancer, the use of topical treatments may be an option, but the presence and levels of arthritis and dementia need to be considered prior to prescribing this treatment.

C) Cardiovascular disease should be considered before planning surgical interventions for older clients with skin cancer.

D) Diabetes should be considered before planning surgical interventions for older clients with skin cancer.

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Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 2.I. Analyze skin cancer as it relates to cellular regulation. Differentiate considerations for care of patients with skin cancer across the lifespan.

MNL LO: Demonstrate understanding of the concept of cellular regulation in the care of a patient with skin cancer.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 3 Comfort

The Concept of Comfort

1) The nurse assesses a client's level of comfort. In which way will the nurse categorize comfort when the client relates having positive family and social relationships?
A) Transcendence
B) Environmental
C) Psychospiritual
D) Sociocultural
Answer: D
Explanation: A) Transcendence is not a context of holistic human experience.
B) Environmental comfort is related to the external surroundings.
C) Psychospiritual comfort is related to the individual awareness of oneself and one's relationship to a higher being.
D) Sociocultural comfort is related to family and social relationships.
Page Ref: 167
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.1. Analyze the physiology of comfort in the body.
MNL LO: Analyze the concept of comfort and its application to nursing care.

2) The nurse is assessing the comfort level of a client with a chronic illness. Which statement indicates that the client is experiencing fatigue?

A) "I feel like I have no energy today."
B) "I don't feel any physical pain today."
C) "I was able to sleep uninterrupted last night."
D) "I am so glad that playing cards takes my mind off my worries."

Answer: A

Explanation: A) Fatigue is a lack of energy and motivation. A fatigued client is unable to focus on healing and lacks the ability to cope in stressful situations.
B) The absence of pain would promote comfort.
C) Adequate sleep will promote comfort.
D) Diversional activities will promote comfort.

Page Ref: 169
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.2. Differentiate alterations in comfort.
MNL LO: Analyze the concept of comfort and its application to nursing care.

3) The nurse is concerned that a client is at risk for discomfort. Which assessment finding caused the nurse to have this concern? **Select all that apply.**
A) Poor diet
B) Drinks beer daily
C) Smokes cigarettes
D) Works 8-hour days
E) Sleeps 4 hours a night
Answer: A, B, C, E
Explanation: A) Lifestyle habits can predispose individuals to chronic health alterations and increase the risk for discomfort. A poor diet is a risk factor.
B) Excessive alcohol intake is a risk factor for chromic health alterations and increased risk for discomfort.
C) Cigarette smoking is a risk factor for chronic health alterations and increased risk for discomfort.
D) Working an 8-hour day is not identified as a risk factor for chronic health alterations or discomfort.
E) Poor sleeping habits is a risk factor for chronic health alterations and increased risk for discomfort.
Page Ref: 171
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.4. Explain the promotion of comfort.
MNL LO: Analyze the concept of comfort and its application to nursing care.

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4) The nurse is preparing to assess a 1-year-old client for signs of discomfort. When conducting the assessment, which action by the nurse is the most appropriate?
A) Asking the client to rate the pain on a scale of 0-10 during the assessment process
B) Asking the parent to hold the client in the lap during the assessment process
C) Reading a book to the client during the assessment process
D) Recommending that the parent leave the room during the assessment process
Answer: B
Explanation: A) A numeric pain scale is not appropriate until the client is older.
B) Children may be fearful of physical assessment. To promote comfort, allow the child to sit on the parent's or guardian's lap during the assessment process.
C) Reading a book during the assessment process is not age appropriate.
D) Ask the parent or guardian to stay in the room during the assessment.
Page Ref: 177
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 3.5. Differentiate common assessment procedures and tests used to examine comfort.
MNL LO: Analyze the concept of comfort and its application to nursing care.

5) The surgical wound of a pediatric client is red with purulent drainage and is causing discomfort for the client. Which diagnostic test will determine if the discomfort of the wound is caused by an infection?

A) White blood cell count
B) Hematocrit level
C) Urine analysis
D) X-rays of the site

Answer: A

Explanation: A) A white blood cell count will determine if the discomfort is being caused by an infection.

B) Hematocrit measurement may identify iron deficiency anemia.

C) Urine analysis may indicate illness or malnutrition.

D) An x-ray is useful for determining the existence of physical injuries, not the presence of infection.

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Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 3.5. Differentiate common assessment procedures and tests used to examine comfort.

MNL LO: Analyze the concept of comfort and its application to nursing care.

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6) An 18-month-old toddler begins to cry when placed on the examination table. Which action by the nurse is the most appropriate?
A) Allow the toddler to sit on the parent's lap and begin the assessment.
B) Allow the toddler to stand on the floor until the crying stops.
C) Ask another nurse in the office to hold the toddler because the parent is not able to control the toddler's behavior.
D) Instruct the parent to hold the toddler down tightly to complete the examination.
Answer: A
Explanation: A) Toddlers are most comfortable when sitting with the parents.
B) Allowing the toddler to stand on the floor is inappropriate.
C) A nurse can assist if the parent is unable to hold the child during the assessment.
D) Holding the toddler down tightly is inappropriate.
Page Ref: 177
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.8. Differentiate considerations related to the assessment and care of patients with alterations in comfort throughout the lifespan.
MNL LO: Analyze the concept of comfort and its application to nursing care.

7) A client arrives for a routine physical examination. Which behavior indicates to the nurse that the client's level of comfort should be assessed? **Select all that apply.**

A) Ambulates slowly
B) Sits with an erect posture
C) Holds arms over the abdomen
D) Grimaces when changing positions
E) Spontaneously responds to questions
Answer: A, C, D
Explanation: A) The client should be observed during every encounter. Altered mobility is an obvious sign of discomfort.
B) Sitting with an erect posture does not indicate discomfort.
C) Guarding is an obvious sign of discomfort.
D) Grimacing when changing positions is an obvious sign of discomfort.
E) Spontaneously responding to questions does not indicate discomfort.
Page Ref: 173
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment
Learning Outcome: 3.5. Differentiate common assessment procedures and tests used to examine comfort.
MNL LO: Analyze the concept of comfort and its application to nursing care.

8) The nurse is designing a teaching plan for community members on ways to prevent chronic pain. Which information should the nurse include in this teaching plan? **Select all that apply.**
A) Eating a healthy diet
B) Obtaining adequate sleep
C) Avoiding illicit drug use
D) Limiting smoking to only before bedtime
E) Avoiding repetitive movements
Answer: A, B, C, E
Explanation: A) Lifestyle habits that predispose individuals to chronic health alterations increase an individual's risk for experiencing discomfort. Eating a healthy diet can prevent the development of chronic diseases that lead to symptoms of discomfort.
B) Lifestyle habits that predispose individuals to chronic health alterations increase an individual's risk for experiencing discomfort. Obtaining adequate sleep can prevent the development of chronic diseases that lead to symptoms of discomfort.
C) Lifestyle habits that predispose individuals to chronic health alterations increase an individual's risk for experiencing discomfort. Using illicit drugs can cause emotional and physical withdrawal symptoms when the drug is no longer used. It is wise to not engage in illicit drug use to prevent the onset of discomfort.
D) Lifestyle habits that predispose individuals to chronic health alterations increase an individual's risk for experiencing discomfort. Smoking can cause emotional and physical withdrawal symptoms when the drug is no longer used. It is wise to not engage in smoking to prevent the onset of discomfort.
E) Lifestyle habits that predispose individuals to chronic health alterations increase an individual's risk for experiencing discomfort. Repetitive movements can increase the risk for injury and fatigue, leading to discomfort.

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Cognitive Level: Synthesizing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 3.4. Explain the promotion of comfort.
MNL LO: Analyze the concept of comfort and its application to nursing care.

9) The nurse is creating a teaching tool about comfort. Which client will the nurse identify that is most likely to reject attempts at comfort?
A) An infant crying
B) A school-age child with abdominal pain who is anxious about a procedure
C) An adolescent with a sleep disorder who doesn't want parental attention
D) An older adult with end-stage renal disease
Answer: C
Explanation: A) An infant crying is verbalizing the need for comfort.
B) A school-age child anxious about a medical procedure craves reassurance.
C) Adolescents may respond to treatment and comfort better if they are treated as adults rather than as children. Some adolescents may reject any offer of comfort, and an adolescent with a sleep disorder who does not want parental attention is probably irritable from the condition and may immediately reject attempts at comfort, at least at first.
D) An older adult with a terminal illness likely will welcome comfort measures even if the client has accepted the likelihood of death.
Page Ref: 178
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.1 Engage with the individual in establishing a caring relationship. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Planning
Learning Outcome: 3.8. Differentiate considerations related to the assessment and care of patients with alterations in comfort throughout the lifespan.
MNL LO: Analyze the concept of comfort and its application to nursing care.

10) During an assessment, a client reports feeling fatigued. Which observation should the nurse use to validate the client's statement? **Select all that apply.**
A) Motivated
B) Confusion
C) Irritability
D) Difficulty sleeping
E) Activity intolerance
Answer: B, C, D, E
Explanation: A) Motivation is not a manifestation of fatigue.
B) A manifestation of fatigue is decreased cognition.
C) Irritability is a manifestation of fatigue.
D) Sleep deprivation is a manifestation of fatigue.
E) Activity intolerance is a manifestation of fatigue.
Page Ref: 169
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: physical comfort and emotional support. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.7. Summarize collaborative therapies used by interprofessional teams for clients with alterations in comfort.
MNL LO: Analyze the concept of comfort and its application to nursing care.

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11) The nurse is caring for a client who begins to vomit. Which lifespan consideration will the nurse take into consideration when assessing the reason for the client's emesis? **Select all that apply.**
A) Signs of discomfort
B) Current medications
C) Known drug allergies
D) Environmental stimuli
E) Current disease processes
Answer: B, C, E
Explanation: A) Signs of discomfort would be taken into consideration if the client reports severe pain or disrupted sleep patterns.
B) Current medications should be taken into consideration if the client displays vomiting.
C) Known drug allergies should be taken into consideration if the client vomits.
D) Environmental stimuli should be taken into consideration if the client is experiencing anxiety.
E) Current disease processes should be taken into consideration if the client vomits.
Page Ref: 174
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment
Learning Outcome: 3.7. Summarize collaborative therapies used by interprofessional teams for clients with alterations in comfort.
MNL LO: Analyze the concept of comfort and its application to nursing care.

12) The nurse is assessing a client's level of comfort. Which finding indicates that the client has psychospiritual comfort?
A) Balance of physical processes
B) Connection to a higher power
C) Connection to others
D) Equilibrium with external circumstances
Answer: B
Explanation: A) Equilibrium with external circumstances is related to the environmental context.
B) Connection to a higher power is related to the psychospiritual context.
C) The sociocultural context of holistic human experience is related to connection with others in society.
D) Equilibrium with external circumstances is related to the environmental context.
Page Ref: 167
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment
Learning Outcome: 3.3. Outline the relationship between comfort and other concepts.
MNL LO: Analyze the concept of comfort and its application to nursing care.

Exemplar 3.A Acute and Chronic Pain

1) The nurse is asked to explain chronic pain. Which response will the nurse make?
A) "Pain that precedes injury."
B) "Pain that follows injury and ends when healing is complete."
C) "Pain that is felt during injury and immediately after."
D) "Pain that outlasts the healing process."
Answer: D
Explanation: A) Chronic pain does not precede injury.
B) Chronic pain does not subside immediately after injury, and it may not be related to an injury.
C) Chronic pain is pain that lasts beyond the expected time of healing, usually for at least 6 months; it does not always have a known cause. Pain can range from mild to severe, and autonomic responses decrease over time as the body adapts to the persistent pain impulses. Chronic pain does not end when healing is complete.
D) Chronic pain is pain that lasts beyond the expected time of healing, usually for at least 6 months; it does not always have a known cause. Pain can range from mild to severe, and autonomic responses decrease over time as the body adapts to the persistent pain impulses.
Page Ref: 182
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.A. Analyze acute and chronic pain as they relate to comfort. Describe the etiology of acute and chronic pain.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with acute and chronic pain.

2) The nurse is reviewing the ceiling effect that can occur with analgesics. Which should the nurse identify as the relationship between a full opioid agonist and the ceiling effect?
A) A full opioid agonist produces few withdrawal symptoms when the drug's effects plateau and the client begins easing off the drug.
B) A client may use a full opioid agonist as much or as little as necessary to control chronic pain with no ill effects.
C) Side effects may limit a full opioid agonist's use but not a plateau in the beneficial effects it produces.
D) At some point, a full opioid agonist's side effects cease to increase in potency, but the pain-relieving effect continues to increase.
Answer: C
Explanation: A) Clients who develop tolerance to opioids are likely to experience withdrawal symptoms.
B) They should be used for clients in severe pain or when other medications have failed to control pain.
C) Full opioid agonists do not have a ceiling effect. Therefore, full opioid agonists can be given in increasing doses until pain is relieved or side effects become intolerable.
D) Full agonists are known to produce euphoria, respiratory depression, and tolerance. Euphoria may help the client feel more comfortable even with uncontrolled pain, but respiratory depression may be a life-threatening side effect.
Page Ref: 192
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 3.A. Analyze acute and chronic pain as they relate to comfort. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with acute and chronic pain.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with acute and chronic pain.

3) The nurse reviews information about the use of nonopioid pain medication for chronic back pain. Which client statement indicates the need for further instruction?

A) "Nonopioid pain medications can have serious side effects I need to consider and watch for carefully."

B) "I should not take a higher than recommended dose because the beneficial effect isn't likely to be higher with a higher dose."

C) "I may use these medications for as long as I think they are necessary."

D) "I may use both opioid and nonopioid medications together, especially to relieve severe pain."

Answer: C

Explanation: A) NSAIDs can produce gastrointestinal (GI) toxicity and prolong bleeding times, and acetaminophen can produce liver and kidney toxicity.

B) Nonopioids have a ceiling effect, so taking a higher dose will not produce a greater analgesic effect.

C) Over-the-counter (OTC) nonopioids are associated with severe side effects, especially when taken long term.

D) While nonopioids are rarely effective alone for severe pain, they may produce a synergistic effect to relieve pain when combined with an opioid.

Page Ref: 190

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 3.A. Analyze acute and chronic pain as they relate to comfort. Apply the nursing process in providing culturally competent care to an individual with acute and chronic pain.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with acute and chronic pain.

4) A toddler being prepared for a lumbar puncture begins to cry when carried into the treatment room by the mother. Which client problem will the nurse use to guide this child's care?
A) Lack of knowledge about pain
B) Anxiety
C) Fear
D) Stress overload
Answer: B
Explanation: A) This child is not old enough to understand the need for a lumbar puncture.
B) The child associates the treatment room with a painful procedure, and the reaction to entering the treatment room is based on anticipation of repeat discomfort.
C) The child's fear is related not to the unfamiliar environment but to the anticipated pain associated with the treatment room from having undergone painful procedures there.
D) The child's behavior is appropriate for coping in a child of this age.
Page Ref: 202
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 3.A. Analyze acute and chronic pain as they relate to comfort. Differentiate care of patients with acute and chronic pain across the lifespan.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with acute and chronic pain.

5) The nurse is creating a pain management plan using the three-step approach for a client with intractable pain. Which interventions should the nurse include in this plan? **Select all that apply.**
A) Administer a nonopioid analgesic first.
B) Administer an opioid analgesic first.
C) Administer a nonopioid with an opioid second.
D) Administer an opioid analgesic last.
E) Administer analgesics upon client request.
Answer: A, C, D
Explanation: A) The first step in the three-step approach to pain management involves administering a nonopioid drug first.
B) An opioid analgesic is not the first step in the three-step approach to pain management.
C) If pain is not adequately controlled with a mild intervention, clients should advance to step 2 and receive a mild opioid in combination with the same or a new nonopioid drug.
D) If the client is still experiencing pain after receiving the nonopioid and the mild opioid, the mild opioid should be replaced with a stronger opioid in step 3.
E) Pain-relieving drugs should be given "by the clock" (every 3-6 hours) rather than on demand to maintain freedom from pain.
Page Ref: 186
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 3.A. Analyze acute and chronic pain as they relate to comfort. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with acute and chronic pain.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with acute and chronic pain.

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6) The nurse is concerned that a client is at risk for injury because of pain. Which statement will the nurse use to explain this risk?

A) Risk for injury is an external risk factor for pain.

B) It is difficult to predict what might pose a risk for injury.

C) Risk for injury can be increased by living a healthy lifestyle.

D) Precautions against risk for injury are rarely successful in preventing injury.

Answer: A

Explanation: A) External risk factors for pain, such as the risk for injury, can be decreased by safety precautions such as wearing a seat belt or helmet.

B) It is not difficult to anticipate what might pose a risk for injury.

C) Internal risk factors for pain, such as the risk of developing a chronic disease, can be decreased by living a healthy lifestyle.

D) The risk for injury can be decreased by safety precautions such as wearing a seat belt or helmet.

Page Ref: 183

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 3.A. Analyze acute and chronic pain as they relate to comfort. Compare the risk factors and prevention of acute and chronic pain.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with acute and chronic pain.

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7) An older client with uterine cancer and chronic pain from arthritis is prescribed long-acting narcotic pain medication every 4 hours. Which action should the nurse take when providing the client with the medication?
A) Administer the medication if the client requests it.
B) Administer the medication every 4 hours around the clock.
C) Consult the provider to order intravenous pain medication.
D) Administer the medication sparingly to avoid narcotic addiction.
Answer: B
Explanation: A) The client shouldn't need to request the medication; the medication should be administered around the clock as prescribed.
B) Administer analgesics as prescribed. Analgesics should be administered around the clock or by self-administration with a patient-controlled analgesic (PCA) pump to keep the pain from becoming severe. In this case, the nurse should follow the prescribed administration plan of every 4 hours around the clock.
C) The nurse should administer the medication orally as prescribed rather than consult the provider for intravenous medication.
D) The medication should be administered around the clock as prescribed rather than sparingly.
Page Ref: 203
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.A. Analyze acute and chronic pain as they relate to comfort. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with acute and chronic pain.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with acute and chronic pain.

8) A preschool-age client needs intravenous medication now and there is no time to use a local anesthetic to reduce the pain from inserting the catheter. Which complementary approach should the nurse use?

A) Simulate the procedure
B) Swaddle the child
C) Guided imagery
D) Distraction using bubbles

Answer: D

Explanation: A) Simulating the procedure would be appropriate for a school-age child.
B) Swaddling would be appropriate for an infant.
C) Guided imagery would be appropriate for a school-age child.
D) Playing games such as blowing bubbles would be appropriate to distract a preschool-age child.

Page Ref: 197

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 3.A. Analyze acute and chronic pain as they relate to comfort. Differentiate care of patients with acute and chronic pain across the lifespan.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with acute and chronic pain.

9) The nurse is creating a teaching tool about the pathophysiology of pain. Which body system should the nurse identify as the trigger for pain?
A) Central nervous system
B) Peripheral nervous system
C) Musculoskeletal system
D) Cardiovascular system
Answer: B
Explanation: A) Pain is not triggered by the central nervous system.
B) Pain is triggered by the peripheral nervous system, which lies outside the brain and spinal cord of the central nervous system.
C) Pain is not triggered by the musculoskeletal system.
D) Pain is not triggered by the cardiovascular system.
Page Ref: 180
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.A. Analyze acute and chronic pain as they relate to comfort. Describe the pathophysiology of acute and chronic pain.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with acute and chronic pain.

10) The nurse is caring for a client who has experienced pain "for years." Which statement describes how the body adapts to pain?
A) The worse pain becomes, the more obvious it is.
B) Once the body adapts to pain, its detrimental effects cease.
C) The observation of pain's effects may become more difficult.
D) The body's sympathetic response increases.
Answer: C
Explanation: A) The sympathetic response returns to baseline levels unless the client experiences breakthrough pain, and some visible signs of pain, such as crying, cease.
B) Pain fibers may become sensitized so that the intensity and perception of pain increase over time.
C) As the body adapts to pain, visible and physiological symptoms of pain may be harder to detect.
D) The sympathetic response returns to baseline levels.
Page Ref: 184
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.A. Analyze acute and chronic pain as they relate to comfort. Identify the clinical manifestations of acute and chronic pain.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with acute and chronic pain.

11) The nurse is preparing a presentation about pain for a community health fair. Which statement will the nurse use to describe all pain?
A) Pain is the result of tissue damage.
B) Pain's effects are primarily physiological, not mental or emotional.
C) Pain can be localized to a particular area of the body.
D) Pain's effects can be verbalized.
Answer: D
Explanation: A) Pain may be the result of tissue damage or a warning of the potential for damage.
B) Pain is both a physical and an emotional experience.
C) Pain may not be localized in its effects.
D) Pain can be described by the client, and so all pain can be verbalized.
Page Ref: 179
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 3.A. Analyze acute and chronic pain as they relate to comfort. Describe the pathophysiology of acute and chronic pain.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with acute and chronic pain.

Exemplar 3.B End-of-Life Care

1) A client with a terminal illness is showing signs of imminent death. Which change should the nurse most expect the client to exhibit first?
A) Decreased blood pressure
B) Blurry vision
C) Confusion
D) Irregular pulse rate
Answer: A
Explanation: A) Low blood pressure, or hypotension, occurs as a client's body begins to near death.
B) Blurry vision is not the change that the client will exhibit first.
C) Confusion is not the first change that will occur first.
D) An irregular pulse rate may be the result of a change in blood pressure when death is imminent.
Page Ref: 207
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.B. Analyze end-of-life care as it relates to comfort. Identify the clinical manifestations seen in patients at the end of life.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient requiring end-of-life care.

2) The family of a competent older adult client plans to contest the client's living will that expresses the desire to avoid resuscitation and life support measures. Which action should the nurse take?

A) Place the document on the chart.

B) Contact the Social Services department.

C) Explain to the client that the conflict could invalidate the document.

D) Notify the hospital attorney.

Answer: A

Explanation: A) The client is competent. The wishes of the client must take priority. The document should first be placed on the chart and the provider notified.

B) If there are concerns about the authenticity of the document, the Social Services department or the unit supervisor will need to be contacted.

C) A lack of support by the family, or a plan to contest, does not invalidate the document legally.

D) There is no need to notify the hospital attorney at this time.

Page Ref: 209

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.1 Engage with the individual in establishing a caring relationship. | NLN Competencies: Relationship Centered Care: Threats to the integrity of relationships, and the potential for conflict and abuse. | Nursing Process: Implementation

Learning Outcome: 3.B. Analyze end-of-life care as it relates to comfort. Describe legal and ethical issues that inform care of patients at the end of life.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient requiring end-of-life care.

3) The family of a client who has suffered a massive cerebral hemorrhage and is not expected to survive informs the nurse that the client is Catholic. Which action should the nurse take?
A) Find a Catholic nurse to continue care for the client.
B) Contact a priest and ask what must be done for the client.
C) Assume the client's desires based on the nurse's understanding of the Catholic faith.
D) Ask the client or the client's family what they want in terms of religious rituals.
Answer: D
Explanation: A) The nurse doesn't need to find a Catholic nurse to continue care.
B) Contacting a priest may be necessary for the client to receive the Anointing of the Sick, but the nurse should follow the client's or family's request in this matter.
C) The nurse should not assume what the client wants in this regard.
D) Cultural and religious beliefs and traditions are often of paramount importance for end-of-life clients and their families. Nurses should work to facilitate requests to every extent possible.
Page Ref: 213
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.1 Engage with the individual in establishing a caring relationship. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 3.B. Analyze end-of-life care as it relates to comfort. Apply the nursing process in providing culturally competent care to an individual at the end of life.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient requiring end-of-life care.

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4) The family of a terminally ill client have been tearful and sad since the diagnosis was given. Which problem should the nurse identify as a priority for the family?
A) Grieving
B) Feelings of hopelessness
C) Inadequate family coping skills
D) Caregiver burden
Answer: A
Explanation: A) Grieving prior to the actual loss is termed anticipatory grieving.
B) There are no assessment findings that indicate feelings of hopelessness.
C) There are no assessment findings that indicate inadequate family coping.
D) There is no indication that the family is exhibiting caregiver burden.
Page Ref: 214
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs.NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 3.B. Analyze end-of-life care as it relates to comfort. Summarize the needs of patients at the end of life.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient requiring end-of-life care.

5) An older adult client with a terminal illness has a living will and requests comfort measures only. Which action will the nurse take when the client reports significant pain, dyspnea, and cold and mottled skin?

A) Ask the family what they want to be done for the client.

B) Withhold all care until the client dies.

C) Contact the provider for orders to control the client's breathing.

D) Provide the client with pain medication as ordered.

Answer: D

Explanation: A) Asking the family what they want to be done is inappropriate when a client has written a living will.

B) Clients with a CMO order should receive effective pain and symptom management, spiritual care, food and fluids as the client is able, and hygiene care.

C) Contacting the provider to intervene to control respiration is considered adding extraordinary measures and is inappropriate, as is going against the client's written wishes when a living will is present and in force.

D) "Comfort measures only" indicates that the client does not want extraordinary measures to sustain life. This does not mean that nursing care ceases but that nursing care to provide client comfort is intensified and maintained through the end stages of the client's life. Clients with a CMO order should receive effective pain and symptom management, spiritual care, food and fluids as the client is able, and hygiene care.

Page Ref: 211

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 3.B. Analyze end-of-life care as it relates to comfort. Describe legal and ethical issues that inform care of patients at the end of life.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient requiring end-of-life care.

6) The nurse is caring for a dying child. Which nursing action supports the primary goal for a dying child?
A) Keep the child entertained so she does not think about dying.
B) Ensure that a good relationship is maintained with the family.
C) Administer pain medication as ordered.
D) Maintain a busy schedule for child and family members.
Answer: C
Explanation: A) Keeping the child entertained is good, but the client needs to voice feelings about death and dying.
B) Maintaining a good relationship is important but not a major goal for the child's care.
C) Children with life-limiting conditions should receive palliative care in much the same way it is provided to adults. The major goal for the dying child is to promote comfort and keep the child pain-free by providing analgesia to promote optimal pain relief.
D) A dying child does not have the energy to maintain a busy schedule.
Page Ref: 190
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 3.B. Analyze end-of-life care as it relates to comfort. Differentiate considerations for the care of children and adolescents who are at the end of life.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient requiring end-of-life care.

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7) The parents of a child with terminal cancer do not want the child to be told of the prognosis. Which action should the nurse take if the child asks about dying?
A) Suggest a meeting with the healthcare team and the parents.
B) If the child asks about death, offer to bring in the child life therapist to help explain the situation.
C) Tell the child they are dying if the child asks and offer to stay with them.
D) Prepare to ignore the child's question if the child asks it and change the subject.
Answer: A
Explanation: A) Offering to set up a meeting with the healthcare team to discuss the parents' fears and concerns about telling their child the truth is the best action by the nurse.
B) The nurse should not simply pass the issue off to a therapist.
C) Telling the child about the prognosis is going against the parents' wishes.
D) Avoiding the subject is not an option.
Page Ref: 211
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 3.B. Analyze end-of-life care as it relates to comfort. Differentiate considerations for the care of children and adolescents who are at the end of life.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient requiring end-of-life care.

8) Parents of an older school-age child with traumatic injuries observe noneffective efforts at resuscitation. Which communication strategy should the nurse use in this situation?
A) Ask the parents whether they would like resuscitative efforts to be continued at this point.
B) Ask the parents to stand at the foot of the cart to watch.
C) Inform the parents that resuscitative efforts have not been effective and are not beneficial to the child.
D) Ask the parents to leave until the child has stabilized.
Answer: C
Explanation: A) Asking the parents if they want resuscitation to continue would not be effective.
B) Asking the parents to watch the resuscitation would be painful for them and should not be done.
C) Care must be used in how the parents are asked to withdraw therapies. An effective communication strategy is to inform the parents that an intervention was initiated to give the child the best chance of recovery, but it has not been effective and is not beneficial to the child.
D) The parents should not be asked to leave; however, they should be asked if they want to stay and the nurse should answer any questions they may have.
Page Ref: 211
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.8. Describe the limits and boundaries of therapeutic patient-centered care. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 3.B. Analyze end-of-life care as it relates to comfort. Differentiate considerations for the care of children and adolescents who are at the end of life.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient requiring end-of-life care.

9) The spouse of a client with end-stage pulmonary disease thinks that hospice is only for people with cancer, it is expensive, and that there will be people in the home at all times. Which responses should the nurse make? **Select all that apply.**

A) Inform the spouse that a diagnosis of cancer is not required for hospice care.

B) Inform the spouse that hospice care is very expensive.

C) Tell the spouse that hospice care is intended to ease the burden of primary caregivers, not add to it by being in the way.

D) Tell the spouse that the client is not eligible for hospice care.

E) Inform the spouse that all hospice programs are provided 24/7 in long-term care facilities.

Answer: A, C

Explanation: A) In addition to clients who are diagnosed with cancer, a variety of clients qualify for hospice care.

B) In many cases, hospice is provided by the individual's health insurance or Medicare policy.

C) Hospice care supports the involvement of family in clients' care and is available to help ease the burden of primary caregivers.

D) To be eligible for hospice care, clients need to be diagnosed by a physician as having 6 months or less to live.

E) Hospice care can take place in the client's home or in hospice centers, hospitals, nursing homes, and other long-term care facilities.

Page Ref: 210

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 3.B. Analyze end-of-life care as it relates to comfort. Contrast palliative and hospice care.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient requiring end-of-life care.

10) An adolescent client with terminal cancer does not want any more treatment, even though the parents want the client to participate in a study trial that involves aggressive chemotherapy. Which action should the nurse take?
A) Tell the client that the parent's decision is to be followed.
B) Tell the client that a 16-year-old can make independent decisions.
C) Request that the parents and client meet with the healthcare team to discuss options and the implications of various choices.
D) Tell the client not to worry.
Answer: C
Explanation: A) The parent's decision does not need to be followed.
B) The Patient Self-Determination Act of 1990 limits the legal rights of individuals younger than 18 to make their own healthcare decisions.
C) If the adolescent states a desire to withdraw from, or refuse, treatment, the parents and healthcare team should discuss the reasons for the decision and help the client understand the implications of the client's decision and any treatment alternatives that may influence the choice.
D) Telling the client not to worry does not address the problem.
Page Ref: 211
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 3.B. Analyze end-of-life care as it relates to comfort. Differentiate considerations for the care of children and adolescents who are at the end of life.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient requiring end-of-life care.

11) A client with a terminal illness is receiving artificial nutrition and hydration. Which action will the nurse take to relieve the client's report of a dry mouth?
A) Mouth care
B) Mechanical ventilation
C) Massage extremities
D) Safety measures
Answer: A
Explanation: A) A client with diminished muscle control might have decreased food and fluid intake resulting from difficulty swallowing and decreased gastrointestinal activity. In addition to providing nutrients and hydration to this client artificially, other clinical therapies might be to provide regular oral care and to provide hygiene care as needed.
B) Mechanical ventilation is therapy for a respiratory problem.
C) Massage would help with a problem with circulation.
D) Safety measures would not help reduce the sensation of a dry mouth.
Page Ref: 212
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.B. Analyze end-of-life care as it relates to comfort. Differentiate therapies used by interdisciplinary teams in the collaborative care of an individual at the end of life.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient requiring end-of-life care.

12) The nurse is caring for a client who is nearing end of life. For which reason should the nurse communicate changes in the client's condition that would warrant a change in the care plan?
A) Nurses typically are responsible for definitively diagnosing patient conditions.
B) Nurses are the healthcare providers who tend to have the greatest amount of contact with clients at the end of life.
C) Clients typically do not prefer to talk to physicians about problems.
D) It is legally mandated that nurses are solely responsible for communicating this information.
Answer: B
Explanation: A) Nurses do not definitively diagnose a client's condition.
B) Collaboration between healthcare providers is essential to providing quality care at the end of life. Nurses interact with clients most frequently, so they are responsible for communicating any changes in the client's condition that would warrant a change in the care plan.
C) Clients often talk to physicians about problems.
D) Nurses are not the only legally mandated people who may communicate changes in a client's condition.
Page Ref: 211
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 3.B. Analyze end-of-life care as it relates to comfort. Differentiate therapies used by interprofessional teams in the collaborative care of an individual at the end of life.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient requiring end-of-life care.

13) The nurse is preparing a teaching tool about care at end of life. Which statement indicates a barrier to pain control?
A) Pain cannot be managed
B) Pain can be predicted
C) Pain is inevitable
D) Pain is acute
Answer: C
Explanation: A) Pain can be managed with appropriate pharmacologic and nonpharmacologic measures.
B) Pain cannot be predicted.
C) A barrier from the client's perspective about pain relief is that pain is inevitable and nothing can be done about it.
D) Pain at end of life can be either acute or chronic.
Page Ref: 214
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.B. Analyze end-of-life care as it relates to comfort. Differentiate therapies used by interprofessional teams in the collaborative care of an individual at the end of life.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient requiring end-of-life care.

Exemplar 3.C Fatigue

1) A client who feels tired after sleeping reports family members complain about the constant snoring. Which condition should the nurse suspect as being the cause of this client's fatigue?
A) Insomnia
B) Depression
C) Thyroid disorder
D) Sleep apnea
Answer: D
Explanation: A) Insomnia is the absence of sleep.
B) There is not enough information to determine if the client is depressed.
C) There is not enough information to determine if the client has a thyroid disorder.
D) The client is snoring at home, which could indicate obstructive sleep apnea.
Page Ref: 216
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.C. Analyze fatigue as it relates to comfort. Describe the pathophysiology, etiology, risk factors, and prevention of fatigue.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fatigue.

2) The nurse is asked for information about lifestyle situations that might contribute to chronic fatigue. Which examples might the nurse identify in response to this request? **Select all that apply.**

A) Thyroid problems
B) Chronic back pain
C) Marijuana use
D) Vigorous exercise three times a week
E) Swimming after a meal

Answer: A, B, C

Explanation: A) Some risk factors for fatigue are hyper- or hypothyroidism.
B) Persistent pain is a risk factor for fatigue.
C) Use of illicit drugs is a risk factor for fatigue.
D) Vigorous exercise will energize, not produce fatigue.
E) Fatigue is a symptom that needs investigating. Some risk factors for fatigue are hyper- or hypothyroidism, use of illicit drugs such as marijuana, and chronic pain. Synthroid use indicates hypothyroidism. Swimming will energize, not produce fatigue.

Page Ref: 216

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 3.C. Analyze fatigue as it relates to comfort. Describe the pathophysiology, etiology, risk factors, and prevention of fatigue.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fatigue.

3) An adolescent client experiencing fatigue reports getting up each day at 6 AM, attending band classes, playing sports for 2 hours after school each day, and then going home to do homework. Which question will the nurse make a priority?
A) "Do you think you are involved in too many activities?"
B) "Do you consume foods high in iron such as red meat and green, leafy vegetables?"
C) "How many hours of sleep do you get each night?"
D) "Have you considered talking with your teachers about decreasing your homework?"
Answer: C
Explanation: A) Asking if the client thinks the number of activities should be reduced does not directly address the number of hours of sleep the client is getting.
B) The history should focus on sleep patterns, not diet.
C) The data in this scenario reveal very little time for sleep; therefore, the history should focus on sleep patterns.
D) Asking if the client thinks the amount of homework should be reduced does not directly address the number of hours of sleep the client is getting.
Page Ref: 219
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 3.C. Analyze fatigue as it relates to comfort. Apply the nursing process in providing culturally competent care to an individual with fatigue.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fatigue.

4) The nurse identifies fatigue as being a problem for a school-age child who gets 10 hours of sleep each night. Which intervention should the nurse add to the client's plan of care?
A) Recommend a sleep study.
B) Recommend a healthy and well-balanced diet with adequate water intake.
C) Recommend that the client's parents keep a journal of activities and sleep patterns.
D) Recommend cognitive-behavioral therapy.
Answer: B
Explanation: A) A sleep study is not indicated for a client who is getting adequate sleep.
B) If the client appears to be getting an adequate amount of sleep each night, then ensuring the client is eating a proper diet would be the first response to fatigue.
C) Keeping a journal of the client's behavior is a step that would follow dietary recommendations if those don't address the fatigue.
D) Cognitive-behavioral therapy is an approach that would follow other, less intensive approaches should they fail to address the fatigue.
Page Ref: 220
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 3.C. Analyze fatigue as it relates to comfort. Differentiate considerations for care of patients with fatigue across the lifespan.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fatigue.

5) A new mother reports being fatigued because the baby is not sleeping well. Which suggestion should the nurse make that would help decrease this client's fatigue?
A) Advise the client to alternate night feedings with the baby's father to allow each parent to rest.
B) Suggest that the client ask the neighbors to babysit one night a week.
C) Ask the physician for medication to restore energy.
D) Increase exercise time each week to promote energy.
Answer: A
Explanation: A) Getting up with the newborn causes fatigue over time. If the parents take turns getting up, each parent will get a full night of rest every other day, which should help with fatigue.
B) Asking someone to babysit once a week will not significantly increase rest time and depends on the sustained commitment of neighbors to giving up a night out of every week.
C) Medications to restore energy are not appropriate in this case.
D) These parents need sleep, and increasing exercise is not a long-term solution for sleep deprivation.
Page Ref: 219
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.C. Analyze fatigue as it relates to comfort. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with fatigue.

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MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fatigue.

6) A client with fatigue is requesting medication for the condition. Which factor should the nurse identify that determines the effectiveness of pharmacologic therapy for fatigue?
A) The client's attitude toward taking medication
B) The length of time the client has been fatigued
C) The appropriateness to the client's condition
D) The client's commitment to complementary therapies
Answer: C
Explanation: A) The client certainly must be willing to take medication, but if the medication isn't appropriate in the first place, the client's willingness doesn't matter.
B) The length of the client's condition isn't a factor.
C) Pharmacologic therapy depends on the cause of fatigue. To be effective, the pharmacologic therapy must be tailored to the client's specific condition.
D) The client's commitment to complementary therapies is not a factor.
Page Ref: 219
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: IX. 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 3.C. Analyze fatigue as it relates to comfort. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with fatigue.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fatigue.

7) The nurse is caring for a client who is experiencing chronic fatigue related to medication being taken for seasonal allergies. Which intervention would most likely help this client?
A) A medication change to treat seasonal allergies
B) Physical therapy to promote exercise
C) Acupuncture and massage
D) Sleep medication to increase rest time
Answer: A
Explanation: A) The nurse might expect the provider to try different dosages or different medications to try to relieve the symptoms.
B) Because the fatigue is due to medication side effects, other strategies will not be effective while the client is on the medication.
C) Therapies such as acupuncture and massage are not consistently supported by clinical studies as effective interventions for fatigue.
D) Because the fatigue is due to medication side effects, other strategies will not be effective while the client is on the medication.
Page Ref: 219
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 3.C. Analyze fatigue as it relates to comfort. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with fatigue.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fatigue.

8) A client has been prescribed iron supplements to treat fatigue and a hemoglobin level of 9. Which additional information should the nurse suggest to help reduce feelings of fatigue associated with a low red blood cell count? **Select all that apply.**

A) Increasing intake of ice cream

B) Drinking a glass of orange juice each day

C) Increasing intake of red meat

D) Increasing intake of wax beans

E) Increasing intake of green, leafy vegetables

Answer: B, C, E

Explanation: A) Ice cream is not a source of dietary iron and does not enhance the absorption of iron.

B) Iron is absorbed better when accompanied with vitamin C in foods such as orange juice.

C) Red meat is a good source of iron that the client can consume in a healthy diet.

D) Wax beans are not a source of dietary iron and do not enhance the absorption of iron.

E) Green, leafy vegetables are good sources of iron that the client can consume in a healthy diet.

Page Ref: 219

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 3.C. Analyze fatigue as it relates to comfort. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with fatigue.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fatigue.

9) A client with multiple sclerosis is complaining of fatigue. In recommending an exercise program to this client, which factor will the nurse need to consider other than physician approval?
A) Complementary dietary recommendations
B) The intensity of the workout
C) Complementary therapy recommendations
D) Pharmacologic therapy
Answer: B
Explanation: A) Complementary dietary recommendations would not be a viable consideration.
B) Clients who report persistent fatigue should be encouraged to begin a physician-approved mild to moderate exercise regimen. Higher intensity exercise does not appear to produce a greater reduction in fatigue, so clients should be instructed to avoid intense workouts that may increase feelings of fatigue. Exercise reduces fatigue in chronic conditions such as multiple sclerosis.
C) Complementary therapies would not be a viable consideration.
D) Pharmacologic therapy would not be a viable consideration.
Page Ref: 219
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 3.C. Analyze fatigue as it relates to comfort. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with fatigue

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fatigue.

10) An adult female client is diagnosed with chronic fatigue syndrome. Which statement should the nurse expect to accompany the diagnosis?
A) Continued bed rest will relieve the condition.
B) The client's physician has ruled out an obvious cause for the fatigue.
C) The client is suffering complications from a severe stress reaction.
D) The client needs a rigorous exercise regimen.
Answer: B
Explanation: A) Bed rest will not relieve the condition.
B) Chronic fatigue syndrome occurs when an individual experiences severe tiredness that lasts more than 6 months, is not caused by a primary condition, and is not relieved by stress reduction. Because this syndrome is not caused by a primary condition and lasts for at least half a year before it is diagnosed, the physician will have ruled out an obvious cause for the fatigue by this point.
C) Chronic fatigue syndrome is not caused by a severe stress reaction.
D) Exercise therapy has produced conflicting results in clients with chronic fatigue syndrome and so should be approached with caution.
Page Ref: 218
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.C. Analyze fatigue as it relates to comfort. Identify the clinical manifestations of fatigue.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fatigue.

11) A pregnant client experiencing fatigue describes her typical diet as consisting of fast food such as burgers and fries for lunch, takeout from Chinese or Mexican restaurants for dinner, and orange juice or a fruit smoothie in the morning. Which issue should the nurse identify with this diet?

A) The fast food because it's likely high in fat.

B) The takeout food might be saucy and heavy.

C) The burgers contain red meat.

D) The fruit smoothies are processed.

Answer: A

Explanation: A) Fatigue in expectant mothers is often caused by iron-deficiency anemia. The fast food would be a problem because it's fatty.

B) It depends on what the client orders to determine if it is too saucy or heavy.

C) Fatigue in expectant mothers is often caused by iron-deficiency anemia. The fast food would be a problem because it's fatty, not because of the red meat content.

D) The fruit smoothies would likely be high in vitamin C and therefore good for this client.

Page Ref: 219

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 3.C. Analyze fatigue as it relates to comfort. Differentiate considerations for care of patients with fatigue throughout the lifespan.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fatigue.

12) The nurse is reviewing data collected from a client during a health history. Which information should the nurse identify as a lifestyle risk factor for fatigue?
A) Chemotherapy
B) Stress
C) Surgery
D) Inactivity
Answer: D
Explanation: A) Chemotherapy is a medical procedure that is a risk factor for fatigue.
B) Stress is a mood disorder that is a risk factor for fatigue.
C) Surgery is a medical procedure that is a risk factor for fatigue.
D) Inactivity is a lifestyle risk factor for fatigue.
Page Ref: 217
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.C. Analyze fatigue as it relates to comfort. Describe the pathophysiology, etiology, risk factors, and prevention of fatigue.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fatigue.

13) The nurse is reviewing data collected during the assessment of a client from a non-English speaking culture. Which word should the nurse use that describes fatigue from culture shock?
A) Linguistic
B) Temporary
C) Geographical
D) Mild
Answer: B
Explanation: A) Culture shock may involve a reaction to changes in language, but not necessarily, and it may be mild or more severe.
B) Culture shock involves adjustment to changes in culture, and so should be temporary in most cases.
C) Culture shock may involve a reaction to changes in geography and may be mild or more severe.
D) Culture shock may be mild or more severe.
Page Ref: 218
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.C. Analyze fatigue as it relates to comfort. Describe the pathophysiology, etiology, risk factors, and prevention of fatigue.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fatigue.

Exemplar 3.D Fibromyalgia

1) The nurse is caring for a client diagnosed with fibromyalgia. Based on this diagnosis, which clinical manifestations might the nurse anticipate for this client? **Select all that apply.**

A) Pain

B) Fatigue

C) Weakness

D) Nausea and vomiting

E) Sleep disturbance

Answer: A, B, E

Explanation: A) Multisite pain is defined as six or more pain sites from a total of nine possible sites located on the head, upper or lower back and spine, chest, abdomen, arms, and/or legs.

B) Fatigue may be mental or physical.

C) Weakness might occur, but it would be caused by fatigue.

D) There is no evidence that nausea or vomiting are symptoms of fibromyalgia.

E) Sleep disturbances cause poor sleep as a manifestation of fibromyalgia.

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Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Identify the clinical manifestations of fibromyalgia.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

2) The adult child of a client with fibromyalgia asks, "Will I get this condition too?" Which responses should the nurse make? **Select all that apply.**
A) If your diet is high in fatty foods, you have a greater chance of developing fibromyalgia.
B) Having a family member with fibromyalgia increases the risk for developing it.
C) If you exercise often enough you'll be fine.
D) Only people aged 30-50 develop fibromyalgia.
E) Fibromyalgia is more prominent in women.
Answer: B, E
Explanation: A) Diets have been suggested as possible treatment but are not thought to cause the disease.
B) Having a family member with the disease increases the risk for development.
C) The disease has not been linked to lack of exercise.
D) There are many theories about the causes of, and risk factors for, fibromyalgia. It is generally conceded that it is more of a problem for women aged 30-50 than for men.
E) It is generally conceded that it is more of a problem for women aged 30-50 than for men.
Page Ref: 221
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Describe the pathophysiology, etiology, risk factors, and prevention of fibromyalgia.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

3) The spouse of a client experiencing pain, sleep disorders, and stiffness believes that nothing is wrong with the client. Which intervention should the nurse add to the family's plan of care?
A) Medications used to treat fibromyalgia
B) An exercise program to increase energy
C) Information and literature on fibromyalgia
D) Suggested dietary changes to help with the pain
Answer: C
Explanation: A) The healthcare provider orders medications.
B) There is no proof that exercise, or lack thereof, causes fibromyalgia.
C) Accepting a disease like fibromyalgia may be difficult due to the vagueness of the disease. Information and written literature may help the family understand that the disease is real.
D) The healthcare provider orders diets.
Page Ref: 224
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Apply the nursing process in providing culturally competent care to an individual with fibromyalgia.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

4) The nurse identifies the problem of chronic pain for a client with fibromyalgia. Which manifestation did the client report that caused the nurse to identify this problem?
A) Pain from eyestrain
B) Pain from a severe skin rash
C) Acute chest pain
D) Tender body points
Answer: D
Explanation: A) Muscle strain of the eye is not a reported symptom.
B) Pain from a rash is not a symptom of fibromyalgia.
C) Acute chest pain is not a symptom of fibromyalgia.
D) Pain from tender body points is a symptom of fibromyalgia.
Page Ref: 224
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Identify the clinical manifestations of fibromyalgia.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

5) The family of a client with fibromyalgia asks what they can do to help the client with painful episodes. Which suggestion should the nurse make?
A) Protect the client from injury.
B) Plan a family reunion or vacation.
C) Divide household chores among each member of the family.
D) Keep the client in bed.
Answer: C
Explanation: A) There is no reason to believe that this client is at higher risk for injury than another member of the family.
B) A family reunion or vacation might cause more stress to the client, who would more than likely be planning and packing for such an event.
C) Although the causes and treatments are not all known, there is general agreement that reducing stress may help lessen the effects of fibromyalgia. The nurse could help the family by suggesting ways to decrease stress on the client by having the family pitch in on responsibilities.
D) Keeping the client in bed would not be therapeutic.
Page Ref: 224
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with fibromyalgia.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

6) The nurse is discussing goals to relieve pain and fatigue with a client newly diagnosed with fibromyalgia. Which goal statement would be realistic for this client to achieve within 30 days?
A) Cook dinner five nights a week.
B) Join an exercise group to meet five nights a week.
C) Walk a child to school daily.
D) Get a job outside the home.
Answer: A
Explanation: A) Fibromyalgia reduces the client's energy. The client might set as an initial goal to be able to perform daily tasks for the family such as cooking and doing the laundry.
B) Joining an exercise group to meet five nights a week would be unrealistic.
C) Walking a child to school daily would be unrealistic.
D) Getting a job outside of the home would be unrealistic.
Page Ref: 224
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Apply the nursing process in providing culturally competent care to an individual with fibromyalgia.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

7) A client is diagnosed with fibromyalgia. Which medication should the nurse anticipate being prescribed as part of the client's treatment plan?
A) Diazepam
B) Milnacipran
C) Aspirin
D) Acetaminophen
Answer: B
Explanation: A) Diazepam is not used to treat fibromyalgia.
B) Milnacipran is a clinical pharmacologic therapy for pain, fatigue, and sleep disruptions for fibromyalgia.
C) Aspirin is not used to treat fibromyalgia.
D) Acetaminophen is not used to treat fibromyalgia.
Page Ref: 222
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with fibromyalgia.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

8) A client with three adolescent children is diagnosed with fibromyalgia and asks how to keep up with all of the children's activities. Which suggestion should the nurse make?
A) Attempt to attend all the functions of the children.
B) Negotiate with the children to alternate attendance of their functions.
C) Avoid attending any afterschool functions for the children.
D) Ask the children to limit their activities.
Answer: B
Explanation: A) It is not reasonable for a client with fibromyalgia to try to run the home and attend all of the functions of each child.
B) Because it is too difficult to attend all of the children's functions, the nurse suggests alternating attendance of the children's functions. In this manner, the client can partially meet the needs of each child.
C) Not attending any functions will only add to the client's stress and may worsen symptoms.
D) The children should not have to limit their activities because of the client's illness.
Page Ref: 224
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Apply the nursing process in providing culturally competent care to an individual with fibromyalgia.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

9) A client with fibromyalgia asks if a recent infection with the Coxsackie B virus could have caused it. Which response should the nurse make?
A) The Coxsackie B virus has nothing to do with fibromyalgia.
B) The Coxsackie B virus may have triggered the fibromyalgia.
C) The Coxsackie B virus definitely caused the fibromyalgia.
D) The Coxsackie B virus probably caused the fibromyalgia.
Answer: B
Explanation: A) Infections such as hepatitis C virus (HCV), HIV, Coxsackie B, and parvovirus may trigger fibromyalgia.
B) Infections such as Coxsackie B may trigger fibromyalgia.
C) Over 70% of clients have no precipitating factor for the disease.
D) The exact cause of fibromyalgia is unknown.
Page Ref: 221
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Describe the pathophysiology, etiology, risk factors, and prevention of fibromyalgia.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

10) The nurse is counseling an adult client with fibromyalgia. Which actions should the nurse take to help the client develop effective coping skills? **Select all that apply.**
A) Ask the client about specific stressors in the client's life and how the client handles them.
B) Inform the client about what to do as the disease worsens.
C) Ask the client about sources of support that the client may be able to rely on.
D) Advise the client that a dimension of self-efficacy is independently developing a response to the problems of fibromyalgia.
E) Suggest to the client that some symptoms may be psychosomatic.
Answer: A, C
Explanation: A) It helps to identify stressors that make pain and fatigue worse, and then develop strategies to avoid those stressors or to minimize symptoms when those stressors occur.
B) Fibromyalgia is not a progressive disease.
C) Getting appropriate help is important in managing fibromyalgia.
D) Clients should be encouraged to see a fibromyalgia specialist, and self-efficacy means engaging in health-promoting behavior to influence the course of the disease, not developing a treatment plan alone.
E) It is important to validate the client's perceptions.
Page Ref: 224
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | Nursing Process: Planning

Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Apply the nursing process in providing culturally competent care to an individual with fibromyalgia.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

11) A 13-year-old female client is diagnosed with juvenile primary fibromyalgia syndrome. Which action should the nurse anticipate for this client?

A) Treat the client in much the same way as an adult with fibromyalgia.

B) Chronic fatigue can be ruled out as a likely clinical manifestation.

C) The client's pain will likely have lasted no more than 3 months.

D) The condition will persist into adulthood.

Answer: A

Explanation: A) JPFS is most commonly diagnosed in girls between the ages of 13 and 15. Triggers and symptoms of JPFS are similar to those of adult fibromyalgia, and so interventions with this client are likely to pertain to pain management, fatigue reduction, and sleep disturbance, just as they would for an adult patient.

B) Chronic fatigue will not be ruled out as a clinical manifestation.

C) Because this client's symptoms are likely to be the same as those of an adult with fibromyalgia, the client is likely to experience chronic fatigue, pain lasting more than 3 months.

D) More than 80% of children with juvenile fibromyalgia syndrome will have fibromyalgia that persists into adulthood.

Page Ref: 223

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Differentiate considerations for care of patients with fibromyalgia across the lifespan.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

12) An adolescent client with juvenile primary fibromyalgia syndrome asks if she can be cured and not deal with it as an adult. Which response should the nurse make?
A) The fibromyalgia likely can be cured with proper sleep hygiene, exercise, and pharmacologic management.
B) Fibromyalgia can be difficult to treat effectively, but the symptoms are unlikely to persist into adulthood.
C) It is likely that the fibromyalgia will persist into adulthood, and there is no cure, but the symptoms can be treated and the condition is not life-threatening.
D) The client will suffer from persistent fibromyalgia for the remainder of her life unless a cure can be found.
Answer: C
Explanation: A) There is no cure for fibromyalgia, but it can be treated symptomatically and it is not progressive or life-threatening.
B) There is no cure for fibromyalgia, but it can be treated symptomatically and it is not progressive or life-threatening.
C) More than 80% of children who have JPFS will have fibromyalgia that persists into adulthood.
D) It is not certain that this client's fibromyalgia will persist into adulthood, but it is likely.
Page Ref: 223
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Differentiate considerations for care of patients with fibromyalgia across the lifespan.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

13) The nurse is asked to describe the pathophysiology of fibromyalgia. Which disorder should the nurse explain as the mechanism of fibromyalgia?
A) Muscle strength
B) Respiratory control
C) Heat regulation
D) Pain processing
Answer: D
Explanation: A) Fibromyalgia is not a disorder of muscle strength.
B) Fibromyalgia is not a disorder of respiratory control.
C) Fibromyalgia is not a disorder of heat regulation.
D) Pain associated with fibromyalgia results from central amplification of pain signals, including spontaneous nerve activity, enlarged receptive fields, and abnormal levels of neurotransmitters.
Page Ref: 221
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Describe the pathophysiology, etiology, risk factors, and prevention of fibromyalgia.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

14) The nurse is asked to describe the etiology of fibromyalgia. Which response will the nurse make?
A) Stress and poor sleep hygiene are the main precipitating factors for fibromyalgia.
B) No exact cause is known, but some clients with fibromyalgia may have precipitating factors.
C) The primary cause for fibromyalgia in nearly all clients who have it is infection.
D) Precipitating factors for fibromyalgia are primarily physiological.
Answer: B
Explanation: A) Stress and poor sleep hygiene might contribute to the development of fibromyalgia in some people.
B) The exact cause of fibromyalgia is unknown; over 70% of clients with fibromyalgia have no precipitating factor for the disease.
C) An infection might cause fibromyalgia but this would not be the precipitating factor in most clients.
D) Psychosocial stressors might be causative factors for fibromyalgia in some clients.
Page Ref: 221
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Describe the pathophysiology, etiology, risk factors, and prevention of fibromyalgia.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

15) The nurse is caring for a client with fibromyalgia. Which finding should the nurse identify as a characteristic of this condition?
A) Difficult to treat
B) Definite as to cause
C) Easy to prevent
D) Brief in its effects
Answer: A
Explanation: A) Fibromyalgia is difficult to treat.
B) No exact cause for fibromyalgia is known, and it may present without precipitating factors.
C) No means of preventing fibromyalgia is known.
D) Fibromyalgia may only be diagnosed if the pain has lasted at least 3 months.
Page Ref: 222
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.D. Analyze fibromyalgia as it relates to comfort. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with fibromyalgia.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with fibromyalgia.

Exemplar 3.E Sleep-Rest Disorders

1) The nurse is reviewing information received during hand-off report. Which client should the nurse identify as exhibiting hypersomnia?

A) The client only gets about 5 or 6 hours of sleep each night.

B) The client gets roughly 8 hours of sleep each night but can't stay awake during the day.

C) The client consistently has trouble getting to sleep and often lies awake for hours after bedtime.

D) The client experiences repetitive involuntary leg movements that interfere with sleep.

Answer: B

Explanation: A) A client getting 5 or 6 hours of sleep each night is experiencing sleep loss.

B) Hypersomnia is a condition of getting enough sleep at night but still exhibiting daytime drowsiness.

C) Difficulty falling asleep is insomnia.

D) Repetitive involuntary leg movements is restless leg syndrome.

Page Ref: 226

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 3.E. Analyze sleep-rest disorders as they relate to comfort. Describe the pathophysiology, etiology, risk factors, and prevention of sleep-rest disorders.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with sleep-rest disorder.

2) A client reports having poor sleep. Which factor differentiates lack of sleep due to a sleep disorder from lack of sleep due to another developing condition?
A) The length of sleep
B) The quality of sleep
C) The symptoms of lack of sleep
D) The cause for the lack of sleep
Answer: D
Explanation: A) The length of sleep may not differ.
B) The quality of sleep may not differ.
C) The symptoms related to the lack of sleep may not differ.
D) The etiology, or cause, of the lack of sleep will differ depending on whether the condition is because of a sleep disorder or another developing condition.
Page Ref: 227
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.E. Analyze sleep-rest disorders as they relate to comfort. Identify the clinical manifestations of sleep-rest disorders.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with sleep-rest disorder.

3) An older adult client is talking with the nurse about sleep problems. Which fact regarding sleep should the nurse teach this client?
A) All elderly individuals experience disrupted sleep and depression.
B) The need for sleep decreases with age.
C) Sleep problems signal the onset of other developing medical conditions.
D) The elderly do not experience as much deep sleep as a younger person.
Answer: D
Explanation: A) Not all elderly people experience depression and sleep disturbances.
B) Generally, the amount of sleep needed is about the same for the youth, middle-aged, and older adult.
C) Sleep problems may be from a sleep disorder as the primary condition and not another developing medical condition.
D) Starting at age 20, there is a reduction in stages 3 and 4 NREM sleep and in REM sleep, which is the deepest sleep. This reduction in deep sleep progresses with aging.
Page Ref: 231
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 3.E. Analyze sleep-rest disorders as they relate to comfort. Differentiate considerations for care of patients with sleep-rest disorders across the lifespan.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with sleep-rest disorder.

4) An older adult client recovering from prostate surgery is waking up frequently during the night. Which client statement supports the problem of disturbed sleep pattern?
A) "The pain in my hips is unbearable at times."
B) "I walk for half an hour after I eat breakfast."
C) "I take my Zoloft as soon as I get up in the morning."
D) "I have one cup of regular coffee in the morning."
Answer: A
Explanation: A) Physical discomfort or pain, especially from osteoarthritis and focused in the hips, often disrupts the sleep of older persons.
B) A short walk in the morning is an appropriate type and timed exercise.
C) The client is taking his prescribed antidepressant medication Zoloft (sertraline hydrochloride) appropriately because it has a stimulant effect and should be taken in the morning.
D) Caffeine intake of one morning cup of coffee should have little interference with sleeping during the night.
Page Ref: 182
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 3.E. Analyze sleep-rest disorders as they relate to comfort. Differentiate considerations for care of patients with sleep-rest disorders across the lifespan.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with sleep-rest disorder.

5) A client with clinical depression reports drinking alcohol before bedtime to help with sleep, but wakes up early with anxiety and the inability to fall asleep again. Which goal would be least appropriate for this client?
A) Avoid the use of alcohol late in the evening.
B) Reduce or remove environmental distractions from the bedroom.
C) Maintain a consistent bedtime.
D) Report decreased snoring.
Answer: D
Explanation: A) For this client, avoiding the use of alcohol late in the evening would definitely be a worthwhile goal.
B) For this client ensuring an environment conducive to sleep would be an appropriate goal.
C) For this client, a routine conducive to sleep would be appropriate.
D) The client's history does not indicate that snoring or apnea is a problem, so a goal related to decreasing snoring is probably least appropriate for this client unless there is reason to suspect this as a problem.
Page Ref: 232
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 3.E. Analyze sleep-rest disorders as they relate to comfort. Apply the nursing process in providing culturally competent care to an individual with a sleep-rest disorder.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with sleep-rest disorder.

6) A resident in an assisted-living facility is restless most nights and sits in the lounge area reading because of insomnia. Which outcome should the nurse expect if the resident continues with this pattern of sleep?
A) Sleep paralysis
B) Onset of cardiac dysfunction
C) Onset of new underdiagnosed health problems
D) The client's activities during the day may be hindered by these episodes.
Answer: D
Explanation: A) Sleep paralysis is a clinical manifestation of narcolepsy, not insomnia.
B) There is no evidence that insomnia leads to cardiac problems.
C) There is no evidence that the resident client is demonstrating underlying problems.
D) Insomnia is defined as an inability to fall asleep, or stay asleep, on most nights for over a month. The individual experiencing insomnia is at risk for daytime drowsiness and may experience cognitive deficits, fatigue, and irritability, all of which can hinder the client's activities during the day.
Page Ref: 226
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 3.E. Analyze sleep-rest disorders as they relate to comfort. Identify the clinical manifestations of sleep-rest disorders.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with sleep-rest disorder.

7) A client with a history of insomnia is scheduled for a polysomnogram that will not include audio and video equipment but will monitor blood oxygen levels, heart rate, breathing, eye and leg movements, and brain waves. Which disorder is least likely to be identified in this test?
A) Periodic limb movement disorder
B) Sleep apnea
C) Sleep talking
D) Restless leg syndrome
Answer: C
Explanation: A) The monitoring of leg movements detects periodic limb movement disorder.
B) Heart rate, breathing, and blood oxygen levels as well as audio monitoring can detect snoring and breathing changes that suggest sleep apnea.
C) Audio and video equipment can also detect parasomnias such as sleep talking, but because such equipment is not being used in this case, the study is least likely to identify this disorder.
D) The monitoring of leg movements detects restless leg syndrome.
Page Ref: 227
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.E. Analyze sleep-rest disorders as they relate to comfort. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a sleep-rest disorder.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with sleep-rest disorder.

8) The nurse is assessing a client for a sleep-rest disorder. Which client behavior is most associated with this disorder?
A) The client answers history questions in detail.
B) The client expresses impatience after two or three questions and insists that the nurse hurry up and finish.
C) The client expresses a concern about the privacy of the information he reveals.
D) The client cannot answer definitely whether he sleeps in strange positions.
Answer: B
Explanation: A) Answering history questions in detail does not demonstrate decreased cognitive functioning.
B) Observation can indicate the presence of fatigue, decreased cognitive functioning and coordination, dark circles under the eyes, and irritability. Expressing impatience after just two or three questions is indicative of irritability, which could be a sign of sleep deprivation from a sleep-rest disorder.
C) A concern about privacy is a normal concern.
D) The client may not be able to answer about strange sleep positions because that may be unknown.
Page Ref: 232
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.E. Analyze sleep-rest disorders as they relate to comfort. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a sleep-rest disorder.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with sleep-rest disorder.

9) The parent of an adolescent is frustrated because the child goes to sleep late and cannot get up in the morning in time for school. Which response by the nurse is the most appropriate?
A) Inform her that several techniques can potentially help correct this problem.
B) Recommend a polysomnography (PSG).
C) Indicate that this is simply a normal change of the body's internal clock associated with puberty, and it will work itself out.
D) Ask about other medical conditions because the adolescent's sleep patterns indicate the onset of a chronic illness.
Answer: A
Explanation: A) Adolescents experience changes in the body's internal clock associated with puberty that in some adolescents cause a delay in melatonin release each night; the result is delayed sleep phase syndrome. Signs of delayed sleep phase syndrome include an inability to fall asleep and wake up at the desired time.
B) A sleep study would only be indicated if the adolescent were experiencing other sleep disturbance symptoms.
C) The use of sleep hygiene, sleep restriction therapy, and relaxation techniques can be beneficial in the treatment of this syndrome.
D) This isn't a sign of another illness but shouldn't be ignored either.
Page Ref: 209
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 3.E. Analyze sleep-rest disorders as they relate to comfort. Differentiate considerations for care of patients with sleep-rest disorders across the lifespan.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with sleep-rest disorder.

10) The nurse instructs an adult client with sleep apnea on the use of a continuous positive airway pressure (CPAP) machine. Which instruction least relates to ensuring the client's comfort with the device?

A) Use a properly sized mask with the straps tight.
B) Instruct the client to wear the mask with air pressure while sleeping.
C) Show how to adjust the pressure to reduce difficulty exhaling.
D) Demonstrate relaxation techniques to reduce a claustrophobic feeling when wearing the mask.

Answer: B

Explanation: A) Wearing the right size mask and keeping the straps tight may ensure comfort when using the device.

B) Wearing the mask with air pressure while sleeping is simply the general way the device should be used and doesn't make any special allowances for the comfort of the client.

C) Reducing the difficulty of exhalation by properly adjusting pressure would ensure comfort when using the device.

D) Relaxation exercises to reduce the claustrophobic feelings caused by wearing the mask would ensure comfort when using the device.

Page Ref: 230

Cognitive Level: Applying

Client Need/Sub: Physiological Adaptation: Basic Care and Comfort

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 3.E. Analyze sleep-rest disorders as they relate to comfort. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a sleep-rest disorder.

MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with sleep-rest disorder.

11) A client seeks medical attention for difficulty sleeping. In which way should the nurse anticipate the client's condition impacts activities of daily living?
A) Interfere
B) Decrease
C) Change
D) Increase
Answer: A
Explanation: A) Sleep disorders can lead to disrupted activities of daily living, and so primarily interfere with such activities.
B) Sleep disorders do not necessarily decrease activities of daily living.
C) Sleep disorders do not necessarily change activities of daily living.
D) Sleep disorders do not necessarily increase activities of daily living.
Page Ref: 232
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: assessment
Learning Outcome: 3.E. Analyze sleep-rest disorders as they relate to comfort. Describe the pathophysiology, etiology, risk factors, and prevention of sleep-rest disorders.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with sleep-rest disorder.

12) A client is diagnosed with sleep apnea. Which difficulty should the nurse expect to assess in this client?
A) Thinking
B) Breathing
C) Waking up
D) Controlling motor functions
Answer: B
Explanation: A) Cognitive deficits are more typical of insomnia.
B) Sleep apnea can manifest as snoring or gasping during sleep, and treatment may involve devices to assist with ventilations during sleep.
C) Frequent awakenings typically accompany sleep apnea, not difficulty waking up.
D) Difficulty controlling the body is more typical of restless leg syndrome.
Page Ref: 226
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 3.E. Analyze sleep-rest disorders as they relate to comfort. Identify the clinical manifestations of sleep-rest disorders.
MNL LO: Demonstrate understanding of the concept of comfort in the care of a patient with sleep-rest disorder.

***Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e* (Pearson)**
Module 4 Digestion

The Concept of Digestion

1) A client presents with delayed wound healing. During the physical assessment, which nutrient deficiency should the nurse anticipate based on the data?
A) Protein
B) Digestive enzymes
C) Insulin
D) Carbohydrates
Answer: A
Explanation: A) A deficiency of protein may delay wound healing.
B) Digestive enzymes aid in the digestion of nutrients.
C) Insulin allows glucose to be used by the cells.
D) Carbohydrates are a source of energy.
Page Ref: 238
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 4.1. Analyze the physiology of digestion in the body.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

2) The nurse is reviewing a list of clients waiting to be seen in the clinic. Which clients are at the highest risk of experiencing severe nausea and vomiting? **Select all that apply.**
A) A 47-year-old with a 3-hour history of chest pressure
B) A 61-year-old reporting sudden onset of vertigo
C) A 72-year-old with an asthma exacerbation
D) A 23-year-old who sustained a head injury in a fall
E) A 19-year-old who is 6 weeks pregnant
Answer: A, B, D, E
Explanation: A) The vomiting center in the medulla of the brain may be affected by an acute myocardial infarction.
B) The vomiting center in the medulla of the brain may be affected by the vestibular system of the ear.
C) An asthma exacerbation is least likely to cause severe nausea and vomiting.
D) The vomiting center in the medulla of the brain may be affected by increased intracranial pressure.
E) The vomiting center in the medulla of the brain may be affected by pregnancy.
Page Ref: 239
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing Process: Assessment

Learning Outcome: 4.3. Outline the relationship between digestion and other concepts.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

3) The nurse is providing care for several clients on a medical-surgical unit. Which condition should the nurse anticipate being treated with surgery?
A) Hepatitis
B) Pancreatitis
C) Pyloric stenosis
D) Malabsorption disorder
Answer: C
Explanation: A) Hepatitis is treated medically.
B) Pancreatitis is treated medically.
C) Pyloric stenosis ultimately requires surgery to split the pyloric muscle to allow passage of food and fluid.
D) Malabsorption disorder is treated medically.
Page Ref: 241
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing Process: Assessment
Learning Outcome: 4.2. Differentiate alterations in digestion.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

4) A 4-month-old infant with vomiting and diarrhea has a temperature of 37°C, apical HR: 130, R: 40/min. The client's abdomen is soft, concave, has 10 gurgles auscultated in 1 minute in all four quadrants, and tympani to percussion. Which collaborative care action should the nurse anticipate?

A) Check the surgical call schedule and reserve an operating suite.

B) Place the infant NPO for a barium swallow.

C) Prepare a milk-based infant formula to replace fluids.

D) Complete a thorough digestion assessment interview with the mother.

Answer: D

Explanation: A) Nothing in the assessment indicates a surgical emergency.

B) A barium swallow is not indicated for diarrhea.

C) Milk-based formulas would be avoided until symptoms subside.

D) The assessment data for this pediatric client indicates a nonemergent alteration in digestion that requires additional interview information from the parent.

Page Ref: 253

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 4.5. Differentiate common assessment procedures and tests used to examine digestion.

MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

5) A client is scheduled for a diagnostic test to determine digestion status. Which test can be completed at any time?
A) Barium swallow
B) Amylase
C) Endoscopy
D) Lipid panel
Answer: B
Explanation: A) A barium swallow requires fasting.
B) An amylase test does not require any special preparation.
C) An endoscopy requires fasting.
D) A lipid panel requires fasting.
Page Ref: 249
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing Process: Planning
Learning Outcome: 4.5. Differentiate common assessment procedures and tests used to examine digestion.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

6) A client with acute pancreatitis is being discharged. What statement indicates that discharge teaching for self-care after hospitalization was effective?
A) "I will avoid onions, caffeine, and spices."
B) "I will take the antibiotics for 2 weeks."
C) "I will avoid alcoholic beverages."
D) "I will get immunized prior to my vacation."
Answer: C
Explanation: A) Onions, caffeine, and spices increase the risk of GERD.
B) Antibiotics are used to prevent pyloric stenosis. Onions, caffeine, and spices increase the risk of GERD.
C) Alcohol increases the risk of pancreatitis.
D) Immunizations can prevent specific types of hepatitis.
Page Ref: 249
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 4.6. Analyze independent interventions nurses can implement for patients with alterations in digestion.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

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7) The nurse is caring for an older adult who recently immigrated and is diagnosed with gastroesophageal reflux disease (GERD). Which intervention would best improve this client's adherence to dietary changes?
A) Scheduling low-fat meal deliveries to the home
B) Providing printed diet information in the native language
C) Interviewing the client to assess the current diet
D) Giving a list of foods to avoid to the spouse
Answer: C
Explanation: A) Scheduling low-fat meal delivery to the home, is not appropriate until the nurse has information on which to base an individualized, culturally sensitive teaching plan.
B) Giving printed diet information is not appropriate until the nurse has information on which to base an individualized, culturally sensitive teaching plan.
C) Interviewing the client to assess the current diet will provide information on which to base a collaborative nutrition plan.
D) Giving a list of foods to avoid to the spouse is not appropriate until the nurse has information on which to base an individualized, culturally sensitive teaching plan.
Page Ref: 240
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 4.6. Analyze independent interventions nurses can implement for patients with alterations in digestion.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

8) The nurse is considering nutritional support for a client experiencing severe side effects of chemotherapy. Which independent and collaborative interventions will best limit the adverse digestive and nutritional effects of chemotherapy?
A) Encourage client to drink 350 mL of clear liquids within 1 hour prior to meals.
B) Position the client flat during intermittent enteral nutrition feedings.
C) Verify that enteral nutrition and total parenteral nutrition (TPN) are never used concurrently.
D) Teach the client relaxation techniques in addition to offering IV ondansetron.
Answer: D
Explanation: A) Nausea is worsened by drinking fluid within 1 hour of meals.
B) Clients should be positioned with the HOB elevated 30 degrees during enteral nutrition feedings.
C) Enteral nutrition and TPN are used concurrently.
D) The American Society of Clinical Oncologists suggests that individuals with cancer who are experiencing nausea and vomiting try distraction, relaxation, positive imagery, and acupuncture. The NCCIH also suggests relaxation techniques for those with chemotherapy-induced nausea and vomiting. Ondansetron is a serotonin receptor agonist used commonly as an antiemetic.
Page Ref: 251
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 4.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in digestion.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

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9) The nurse is preparing a presentation to a group of adolescent clients regarding proper nutrition. Which information is appropriate for this group?
A) The high metabolism of the typical adolescent lowers nutritional requirements.
B) It is normal for adolescents to consume a lot of calories, but their diet should still be balanced.
C) Roughly half of an adolescent's daily caloric intake should come from fats.
D) The taste preferences of adolescents typically correlate to the nutritional value of what they eat.
Answer: B
Explanation: A) The high metabolism of the typical adolescent raises nutritional requirements.
B) Bodily demands for calories and nutrients increase dramatically during this time. Adolescent girls require about 2200 calories per day, and adolescent boys require about 2800 calories per day.
C) Roughly 50% of calories should come from complex carbohydrates, 30% from fats, and 20% from proteins.
D) Taste preferences are one of the contributing factors to adolescents exceeding fat intake requirements and not getting enough other nutrients or vitamins, minerals, and fiber.
Page Ref: 255
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 4.8. Differentiate considerations related to the assessment and care of patients with alterations in digestion throughout the lifespan.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

10) The nurse is caring for a 6-month-old infant with pyloric stenosis. Which statement regarding this client's digestive system should the nurse question?
A) The client has voluntary control over swallowing.
B) Enzymes from the client's pancreas are sufficient to aid in digestion.
C) The client has a complete set of primary teeth.
D) The client's tongue is larger than an adult's in comparison to the nasal and oral passages.
Answer: C
Explanation: A) An infant develops voluntary control over swallowing by 6 weeks.
B) Enzymes are sufficient to aid in digestion by 4-6 months, so an infant at 6 months should have sufficient enzymes for digestion.
C) Most children have a complete set of primary teeth by 3-6 years of age. At 6 months, the first teeth begin to erupt.
D) The infant's tongue is larger than that of a child or adult in comparison to the nasal and oral passages.
Page Ref: 253
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 4.8. Differentiate considerations related to the assessment and care of patients with alterations in digestion throughout the lifespan.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

Exemplar 4.A Gastroesophageal Reflux Disease

1) The nurse is explaining the alteration in normal function to a client recently diagnosed with gastrointestinal reflux disease (GERD). Which etiology contributing to GERD will the nurse include in the teaching session?
A) Transient constriction of the lower esophageal sphincter
B) Decreased pressure within the stomach
C) Incompetent lower esophageal sphincter
D) Prolonged constriction of the upper esophageal sphincter
Answer: C
Explanation: A) The lower esophageal sphincter is normally constricted except during swallowing.
B) Increased pressure in the stomach can cause acid to reflux into the esophagus.
C) An incompetent lower esophageal sphincter remains open, allowing gastric acid to reflux into the esophagus.
D) The action of the upper esophageal sphincter is not a cause of GERD.
Page Ref: 256
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 4.A. Analyze GERD as it relates to digestion. Describe the etiology of GERD.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

2) The nurse is providing care to several clients in an outpatient clinic. Which client is at high risk of developing gastroesophageal reflux disorder (GERD)?

A) A client who is 6 weeks pregnant
B) A client who is morbidly obese
C) A client who follows a strict vegetarian diet
D) A client who drinks one glass of wine monthly

Answer: B

Explanation: A) Pregnancy is an increasing risk factor in the later stages due to pressure on the stomach.
B) Obesity is a risk factor for GERD.
C) A vegetarian diet is not a risk factor for GERD.
D) Rare alcohol consumption is not as strong a risk factor for GERD as morbid obesity.

Page Ref: 256
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care.
Nursing Process: Assessment
Learning Outcome: 4.A. Analyze GERD as it relates to digestion. Compare the risk factors and prevention of GERD.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

3) The nurse instructs the parent of a pediatric client with gastroesophageal reflux disorder (GERD) on feeding approaches. Which observation demonstrates correct procedure for preventing GERD symptoms?
A) Burping the infant after 4 ounces of formula are taken
B) Thinning the formula with water prior to feeding
C) Positioning the infant upright for a minimum of 30 minutes
D) Warming the formula prior to feeding
Answer: C
Explanation: A) Infants with GERD should be burped after every 1-2 ounces of formula are taken.
B) Pre-thickened formulas can also reduce GERD symptoms.
C) Positioning the infant upright for 30 minutes after a feeding can reduce GERD symptoms.
D) Warming the formula does not impact GERD symptoms.
Page Ref: 260
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 4.A. Analyze GERD as it relates to digestion. Differentiate care of patients with GERD across the lifespan.

MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

4) A client with burning pain in the chest of a 7 on a 0 to 10 pain scale is diagnosed with gastroesophageal reflux disorder (GERD) secondary to hiatal hernia. Which problem will the nurse make a priority?
A) Impaired gastrointestinal motility
B) Lack of knowledge about nutrition
C) Acute pain
D) Inadequate health maintenance skills
Answer: C
Explanation: A) There is no evidence that the client has impaired gastrointestinal motility. Dysfunctional gastrointestinal motility and ineffective health maintenance are less urgent.
B) There is no evidence that the client lacks knowledge about nutrition.
C) Acute pain management is the priority of nursing care.
D) There is no evidence that the client has inadequate health maintenance skills.
Page Ref: 261
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 4.A. Analyze GERD as it relates to digestion. Apply the nursing process in providing culturally competent care to an individual with GERD.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

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5) A client with a history of gastroesophageal reflux disorder (GERD) presents with metabolic alkalosis. Which medication should the nurse suspect contributed to the acid-base imbalance?

A) Aluminum hydroxide
B) Omeprazole
C) Ranitidine
D) Metoclopramide

Answer: A

Explanation: A) Aluminum hydroxide antacids neutralize gastric acid. Overuse of antacids may cause metabolic acidosis.
B) Omeprazole does not cause metabolic alkalosis.
C) Ranitidine does not cause metabolic alkalosis.
D) Metoclopramide does not cause metabolic alkalosis.

Page Ref: 259

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 4.A. Analyze GERD as it relates to digestion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with GERD.

MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

6) An adult client with a BMI of 39 and who smokes 1 pack of cigarettes per day is diagnosed with erosive esophagitis. Which recommendation should the nurse make when the client refuses oral medications as treatment? **Select all that apply.**
A) Assess the client's readiness for change in smoking cessation and weight loss.
B) Interview the client and spouse for a 24-hour recall of usual food content, intake, and meal times.
C) Enlist the client's son to elevate the foot of the client's bed at home 6 inches.
D) Offer the client a surgical consult to reduce the necessity of medication.
E) Omit the pharmacist notification of the interprofessional team meeting about the client.
Answer: A, B
Explanation: A) Weight loss and smoking cessation will improve the symptoms of GERD.
B) Determining food types, amounts, and times of consumption can help the client avoid foods that stimulate acid production and avoid eating prior to lying down.
C) The head of the bed should be elevated and the team should recommend this to the client rather than enlisting the client's son.
D) A surgical consult should come from the primary provider and will not necessarily reduce the need for medication.
E) The pharmacist should be included in the interprofessional team meeting to give input to strategies to improve the client's receptivity to medication therapy.
Page Ref: 258
Cognitive Level: Applying
Client Need/Sub: Physiological Adaptation: Physiological Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation and therapies used by interprofessional teams in the collaborative care of an individual with GERD.

Learning Outcome: 4.A. Analyze GERD as it relates to digestion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with GERD.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

7) The nurse implements a plan of care for an adult client with gastroesophageal reflux disorder (GERD). Which statement indicates to the nurse that the client has been adhering to the plan?
A) "I can wear snug spandex camisoles if I feel comfortable."
B) "I have switched from margaritas to wine."
C) "I've lost 6 pounds because I eat every 3 hours and never before bed."
D) "I take a Tums with the ranitidine to make it work better."
Answer: C
Explanation: A) Tight-fitting clothing such as spandex camisoles can worsen GERD, regardless of whether the client feels comfortable wearing them.
B) Changing from margaritas to wine will not improve GERD.
C) Appropriate client outcomes are freedom from pain and knowledge of lifestyle changes to manage GERD. Weight loss, small, frequent meals, and avoiding lying down within 3 hours of eating indicate correct management.
D) Antacids such as Tums should be avoided within 1 hour before or after an H_2-receptor blocker like ranitidine.
Page Ref: 262
Cognitive Level: Evaluating
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 4.A. Analyze GERD as it relates to digestion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with GERD.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

8) The nurse is assessing a 9-month-old infant who is having symptoms of gastroesophageal reflux disease (GERD). Which finding would be unusual for the nurse to assess?
A) Weight gain
B) Vomiting
C) Irritability
D) Wheezing
Answer: A
Explanation: A) Weight gain would be normal and not a clinical manifestation of GERD in a client aged 9 months.
B) Clinical manifestations of GERD in children younger than 1 year including vomiting.
C) Clinical manifestations of GERD in children younger than 1 year may include irritability.
D) Respiratory symptoms such as choking, wheezing, and coughing may also occur.
Page Ref: 260
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 4.A. Analyze GERD as it relates to digestion. Differentiate care of patients with GERD across the lifespan.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

9) A pregnant client in the second trimester is experiencing worsening gastroesophageal reflux disease (GERD). Which information should the nurse question for this client?
A) Eating smaller and more frequent meals.
B) Avoiding foods that are known to be triggers for GERD.
C) Proton pump inhibitors (PPIs) are safe to use, with the exception of omeprazole.
D) The use of antacids containing sodium bicarbonate is recommended.
Answer: D
Explanation: A) Eating small, frequent meals may help the symptoms.
B) Avoiding foods that trigger symptoms may help the symptoms.
C) The majority of PPIs are considered safe for use by pregnant women; the exception is omeprazole. The FDA has concerns about fetal safety associated with maternal omeprazole use.
D) Antacids that contain sodium bicarbonate can lead to fluid retention, and pregnant women should avoid using them. Antacids that contain calcium carbonate, which do not cause fluid retention, may be an appropriate alternative.
Page Ref: 261
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 4.A. Analyze GERD as it relates to digestion. Differentiate care of clients with GERD across the lifespan.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with gastroesophageal reflux disease.

Exemplar 4.B Hepatitis

1) A client is diagnosed with viral hepatitis transmitted by the fecal-oral route. Which conditions may be acquired by this mode of transmission?
A) Hepatitis A (HAV) and hepatitis E (HEV)
B) Hepatitis B (HBV) and hepatitis C (HCV)
C) Hepatitis D (HDV)
D) Hepatitis A (HAV), hepatitis B (HBV), hepatitis C (HCV), hepatitis D (HDV), and hepatitis E (HEV)
Answer: A
Explanation: A) Hepatitis A (HAV) and hepatitis E (HEV) are transmitted by the fecal-oral route.
B) Hepatitis C (HCV) is transmitted through blood and body fluids. Hepatitis B (HBV) is transmitted by blood, body fluids, and perinatal routes.
C) Hepatitis D (HDV) is transmitted by blood, body fluids, and perinatal routes.
D) Hepatitis A (HAV) and hepatitis E (HEV) are transmitted by the fecal-oral route. Hepatitis C (HCV) is transmitted through blood and body fluids. Hepatitis B (HBV) and hepatitis D (HDV) are transmitted by blood, body fluids, and perinatal routes.
Page Ref: 264
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 4.B. Analyze hepatitis as it relates to digestion. Describe the etiology of hepatitis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with hepatitis.

2) The nurse instructs a group of high school students on the transmission of hepatitis. Which student statement indicates the need for further education?
A) "Body piercing or tattoo with infected equipment."
B) "Contaminated food or fluids."
C) "Alcoholism or high doses of acetaminophen."
D) "Bite of an infected mosquito or tick."
Answer: D
Explanation: A) Body piercings or tattoos with infected equipment can cause hepatitis.
B) Contaminated food or fluids can cause hepatitis.
C) Alcoholism or high doses of acetaminophen can cause hepatitis.
D) Hepatitis is not caused by the bite of a mosquito or tick.
Page Ref: 264
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 4.B. Analyze hepatitis as it relates to digestion. Compare the risk factors and prevention of hepatitis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with hepatitis.

3) An adolescent client recently diagnosed with hepatitis lives with the parents. Which recommendation to the client's parents will best prevent them from acquiring hepatitis B (HBV)?
A) Refuse to donate blood.
B) Avoid contaminated water.
C) Obtain postexposure prophylaxis.
D) Abstain from alcohol.
Answer: C
Explanation: A) Donating blood will not increase the risk of acquiring HBV.
B) HBV is not spread in water.
C) Obtaining postexposure prophylaxis treatment will best help the client's parents from acquiring HBV.
D) Alcohol abuse is implicated in nonviral hepatitis.
Page Ref: 268
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 4.B. Analyze hepatitis as it relates to digestion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a congenital heart defect.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with hepatitis.

4) An older client with acute hepatitis B has fatigue, avoids sexual intercourse, drinks 3 to 5 alcohol beverages a week, has right upper quadrant abdominal pain, and pruritis. Which findings indicate that the client's hepatitis may have progressed to a chronic stage? **Select all that apply.**
A) Fatigue
B) Drinks 3-5 mixed drinks weekly socially
C) RUQ pain
D) Pruritus
E) Avoiding sexual intercourse
Answer: A, C, D
Explanation: A) Fatigue is a clinical manifestation of chronic hepatitis.
B) The client being a social drinker does not indicate anything about the progress of the client's hepatitis.
C) Right upper quadrant abdominal pain is a clinical manifestation of chronic hepatitis.
D) Pruritis is a clinical manifestation of chronic hepatitis.
E) Avoiding sexual intercourse is not a manifestation of chronic hepatitis.
Page Ref: 266
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Evidence and best practices for nursing. | Nursing Process: Assessment
Learning Outcome: 4.B. Analyze hepatitis as it relates to digestion. Differentiate care of patients with hepatitis across the lifespan.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with hepatitis.

5) The nurse is planning care for a client with chronic hepatitis. Which collaborative discipline will be most helpful in treating continued alcohol use?
A) Social worker
B) Primary provider
C) Pharmacist
D) Dietitian
Answer: A
Explanation: A) The social worker is an expert at identifying additional resources for treatment of substance abuse.
B) The primary provider will contribute to the plan of care.
C) The pharmacist will contribute to the client's plan of care.
D) The dietician will contribute to the client's plan of care.
Page Ref: 267
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 4.B. Analyze hepatitis as it relates to digestion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hepatitis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with hepatitis.

6) A client who, with symptoms of the prodromal phase of hepatitis, has a positive anti-HAV IgM. Which interventions should the nurse add to the client's plan of care? **Select all that apply.**
A) High-fat, low-calorie, and no-alcohol diet teaching
B) Instruct on acceptable pain medication
C) Early treatment with lamivudine
D) Referral to the liver transplant team
E) Family teaching for transmission prevention
Answer: B, E
Explanation: A) A low-fat, high-calorie diet is recommended.
B) Education on acceptable pain medication is necessary due to the toxic effect of common over-the-counter pain medicine.
C) Most clients recover from acute viral hepatitis without pharmacologic treatment.
D) Most clients recover from acute viral hepatitis without a liver transplant.
E) Family teaching is appropriate to avoid transmission.
Page Ref: 270
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 4.B. Analyze hepatitis as it relates to digestion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a congenital heart defect.

MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with hepatitis.

7) A young adult who works in a restaurant has been treated for viral hepatitis at a healthcare clinic. Which client outcome indicates the need for additional intervention? **Select all that apply.**
A) Body mass index (BMI) changes from 24 to 21.
B) Return demonstration of hand washing is correctly performed.
C) Social Services notified the Health Department of the occurrence.
D) Red scratch marks are noted on the arms and trunk.
E) Client denies abdominal or epigastric pain.
Answer: A, D
Explanation: A) The client will need additional intervention if weight loss occurs.
B) No additional intervention is needed if hand washing is performed correctly.
C) The health department must be notified if a food service worker is diagnosed due to possible exposure of patrons.
D) The client will need additional intervention if continued itching occurs as evidenced by the red scratch marks.
E) No additional intervention is needed if pain is controlled.
Page Ref: 271
Cognitive Level: Evaluating
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 4.B. Analyze hepatitis as it relates to digestion. Apply the nursing process in providing culturally competent care to an individual with hepatitis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with hepatitis.

8) The nurse is planning a teaching session for expectant mothers regarding pediatric clients and hepatitis. Regarding hepatitis A, which statement is correct?
A) Infection of the mother is the most common reason hepatitis A spreads to children.
B) A daycare is typically a high-risk environment for the spread of hepatitis A.
C) Children with hepatitis A are commonly asymptomatic.
D) Hepatitis A in children is typically a very serious illness with long-term health effects.
Answer: B
Explanation: A) Hepatitis A is not perinatal.
B) Hepatitis A is the most common type of hepatitis in children and is often spread at daycare centers where children are in diapers or are being potty trained.
C) Children with hepatitis B may be asymptomatic, but in the majority of cases, hepatitis A is mild and causes flulike symptoms.
D) In the majority of cases, hepatitis A rarely has long-term consequences.
Page Ref: 267
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 4.B. Analyze hepatitis as it relates to digestion. Differentiate care of patients with hepatitis across the lifespan.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with hepatitis.

9) A nurse is caring for a client diagnosed with an HBV infection. Which clinical manifestation indicates that the client had entered the icteric phase?
A) Fatigue
B) Jaundice
C) Loss of appetite
D) Nausea
Answer: B
Explanation: A) Fatigue normally occurs in hepatitis B.
B) The icteric phase begins with the onset of jaundice, approximately 5-10 days after initial symptoms manifest, although some clients will never develop jaundice.
C) Loss of appetite occurs during the prodromal phase of the infection.
D) Nausea can occur during the prodromal phase of the infection.
Page Ref: 266
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 4.B. Analyze hepatitis as it relates to digestion. Identify the clinical manifestations of hepatitis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with hepatitis.

Exemplar 4.C Malabsorption Disorders

1) A client with celiac disease experiences frequent diarrhea. Which additional problems should the nurse anticipate in this client? **Select all that apply.**
A) Skin breakdown
B) Fluid and electrolyte imbalance
C) Hair loss
D) Lifestyle issues
E) Sexual dysfunction
Answer: A, B, D
Explanation: A) Clients with diarrhea may have perianal skin irritation and skin breakdown.
B) Diarrhea disturbs the fluid and electrolyte balance and can disrupt normal life activities.
C) There is no known direct connection between diarrhea and hair loss.
D) Diarrhea can disrupt normal life activities.
E) There is no known direct connection between diarrhea and sexual dysfunction.
Page Ref: 274
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 4.C. Analyze malabsorption disorders as they relate to digestion. Identify the clinical manifestations of malabsorption disorders.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with a malabsorption disorder.

2) An older adult, African American client with a history of celiac disease experiences abdominal cramps, pain, and diarrhea after eating foods such as steak, cheese, and ice cream. Which condition should the nurse suspect is occurring with this client?
A) Acute pancreatitis
B) Appendicitis
C) Lactase deficiency
D) Food poisoning
Answer: C
Explanation: A) The most common risk factor for pancreatitis is alcohol abuse.
B) Appendicitis usually involves loss of appetite and nausea and/or vomiting soon after abdominal pain begins.
C) Lactose intolerance is more common in Native Americans, Asians, Hispanics, and African Americans and in those with a history of celiac disease.
D) Food poisoning generally causes some nausea and vomiting.
Page Ref: 274
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 4.C. Analyze malabsorption disorders as they relate to digestion. Compare the risk factors and prevention of malabsorption disorders.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with a malabsorption disorder.

3) A school nurse is providing care to a number of school-age children diagnosed with celiac disease. Which interventions are appropriate for the nurse to implement with this group of students? **Select all that apply.**

A) Teaching about gluten-free food choices

B) Emphasizing low-calorie food selections

C) Implementing a school-based prevention program to eliminate the disease process

D) Labeling gluten-free choices in the school lunch program

E) Demonstrating coping strategies for living with celiac disease

Answer: A, D, E

Explanation: A) Appropriate interventions for the school nurse to implement include teaching the children with celiac disease about gluten-free food choices.

B) Food selections should be high in calories and protein.

C) Celiac disease cannot be prevented.

D) The nurse would implement the labeling of gluten-free food choices in the school lunch program to aid the children in choosing foods to eat while at school.

E) School-age clients may also benefit from learning about coping strategies.

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Cognitive Level: Applying

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 4.C. Analyze malabsorption disorders as they relate to digestion. Differentiate care of patients with malabsorption disorders across the lifespan.

MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with a malabsorption disorder.

4) An older adult client lives alone, has limited financial resources, and has a history of celiac disease. Which problems should the nurse focus on when planning care for this client? **Select all that apply.**

A) Constipation

B) Undernutrition

C) Fluid volume excess

D) Diarrhea

E) Chronic pain

Answer: B, C, D, E

Explanation: A) Constipation is not a symptom of celiac disease.

B) Clients with celiac disease often have nutritional imbalance, including anemia and vitamin deficiencies.

C) Clients with celiac disease often have a fluid imbalance.

D) Clients with celiac disease often have impaired absorption of fluids and electrolyte, which leads to diarrhea.

E) Clients with celiac disease often have pain related to abdominal bloating and cramping.

Page Ref: 275

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

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Learning Outcome: 4.C. Analyze malabsorption disorders as they relate to digestion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a malabsorption disorder.

MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with a malabsorption disorder.

5) A school-age child, recently diagnosed with celiac disease, is underweight, vitamin deficient, and anemic and experiences frequent diarrhea. In addition to removing gluten from his diet, which additional recommendations should the nurse provide for this child and family? **Select all that apply.**

A) Fat restriction
B) A high-carbohydrate diet
C) Vitamin supplements
D) High-calorie diet
E) High-protein diet

Answer: A, C, D, E

Explanation: A) A child with celiac disease who is underweight, vitamin-deficient, anemic, and experiencing diarrhea will require a low-fat diet.

B) In celiac disease, gastrointestinal dysfunction may cause carbohydrates to be incompletely digested, leading to malabsorption and intolerance.

C) Vitamin supplements are also likely required given that this child is vitamin deficient.

D) A child with celiac disease who is underweight, vitamin-deficient, anemic, and experiencing diarrhea will require a high-calorie diet.

E) A child with celiac disease who is underweight, vitamin-deficient, anemic, and experiencing diarrhea will require a high-protein diet.

Page Ref: 274

Cognitive Level: Applying

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 4.C. Analyze malabsorption disorders as they relate to digestion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a malabsorption disorder.

MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with a malabsorption disorder.

6) Parents of a child diagnosed with celiac disease have requested guidance on how to implement an appropriate diet. In addition to a list of foods to include and exclude, which interventions by the nurse are appropriate? **Select all that apply.**
A) Obtaining a dietary prescription
B) Implementing a recommended exercise program
C) Training on how to read food labels
D) Providing a referral to support groups
E) Encouraging the use of a gluten-free cookbook
Answer: A, C, D, E
Explanation: A) Education that should be provided to the child and their family include obtaining a dietary prescription that will enable them to deduct the cost of special ingredients and commercially prepared products as a medical expense.
B) Exercise is not considered an intervention that is specifically aimed at treating celiac disease.
C) Education that should be provided to the child and their family includes education on how to read a food label.
D) Education that should be provided to the child and their family includes referrals to a support group.
E) Education that should be provided to the child and their family includes encouraging the use of a gluten-free cookbook.
Page Ref: 275
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 4.C. Analyze malabsorption disorders as they relate to digestion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a malabsorption disorder.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with a malabsorption disorder.

7) The nurse is providing care to a pediatric client diagnosed with celiac disease. Which outcomes can be anticipated when the appropriate steps for managing celiac disease have been implemented? **Select all that apply.**

A) The client is free of abdominal discomfort including bloating, gas, indigestion, nausea, and vomiting.
B) The client is able to maintain normal or routine bowel habits.
C) The client has diarrhea fewer than 3 days weekly.
D) The client is able to maintain adequate nutritional status.
E) The client is able to make appropriate menu choices prior to discharge.

Answer: A, B, D, E

Explanation: A) When the client with celiac disease is placed on a gluten-free diet, treatment generally is successful, as long as the client avoids gluten totally. Symptoms such as diarrhea and abdominal discomfort should be eliminated.
B) When the client with celiac disease is placed on a gluten-free diet, treatment generally is successful, as long as the client avoids gluten totally. Symptoms such as diarrhea and abdominal discomfort should be eliminated.
C) Symptoms such as diarrhea should be eliminated.
D) Nutritional status should improve.
E) The client should be able to make menu choices to prevent symptoms associated with celiac disease.

Page Ref: 275
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 4.C. Analyze malabsorption disorders as they relate to digestion. Apply the nursing process in providing culturally competent care to an individual with a malabsorption disorder.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with a malabsorption disorder.

8) A client expresses the desire to become pregnant and asks how a gluten-free diet might help. Which information should the nurse question as a benefit of a gluten free diet for this client?
A) A gluten-free diet may lower the risk of infertility.
B) A gluten-free diet may lower the risk of miscarriage.
C) A gluten-free diet may increase the probability that the child's birth weight will be healthy.
D) A gluten-free diet may improve fetal bone development.
Answer: D
Explanation: A) Research suggests that female infertility is linked to celiac disease.
B) Women with celiac disease are at increased risk for miscarriage.
C) Low infant birth weight is also more prevalent among mothers with celiac disease than among the general population.
D) Calcium is critical for fetal bone development, and pregnant women should consume around 1000 mg of calcium per day, but this is a separate issue from maintaining a gluten-free diet.
Page Ref: 279
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 4.C. Analyze malabsorption disorders as they relate to digestion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a malabsorption disorder.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with a malabsorption disorder.

9) The nurse is asked to describe the role of gluten in celiac disease. Which response will the nurse make?
A) It acts as a toxin damaging the villi of the small intestine.
B) It acts as an immunological body to destroy pathogens.
C) It acts as a virus to cause disease.
D) It acts as a substance that causes a sensitivity reaction.
Answer: D
Explanation: A) Gluten does not act like a toxin.
B) Gluten does not act like an immunological body to destroy pathogens.
C) Gluten does not act like a virus.
D) Gluten acts as a substance that causes a sensitivity reaction.
Page Ref: 273
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 4.C. Analyze malabsorption disorders as they relate to digestion. Describe the pathophysiology of malabsorption disorders.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with a malabsorption disorder.

Exemplar 4.D Pancreatitis

1) The nurse is providing care to a client admitted with acute pancreatitis. Which data support the client's diagnosis? **Select all that apply.**
A) Severe epigastric pain
B) Nausea and vomiting
C) Elevated temperature
D) Hypotension
E) Steatorrhea
Answer: A, B, C, D
Explanation: A) Acute pancreatitis presents with severe epigastric pain.
B) Acute pancreatitis presents with nausea and vomiting.
C) Acute pancreatitis presents with an elevated temperature.
D) Acute pancreatitis presents with hypotension.
E) Steatorrhea is a clinical manifestation that is associated with chronic pancreatitis.
Page Ref: 282
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 4.D. Analyze pancreatitis as it relates to digestion. Identify the clinical manifestations of pancreatitis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pancreatitis.

2) The nurse is providing care to a client who is being admitted to rule out acute pancreatitis. Which condition in the history increases the client's risk for this disease process?
A) Systemic lupus
B) Alcoholism
C) Cystic fibrosis
D) Hypertriglyceridemia
Answer: B
Explanation: A) Systemic lupus is a risk factor for chronic pancreatitis.
B) Alcoholism is a risk factor for acute pancreatitis.
C) Cystic fibrosis is a risk factor for chronic pancreatitis.
D) Hypertriglyceridemia is a risk factor for chronic pancreatitis.
Page Ref: 281
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 4.D. Analyze pancreatitis as it relates to digestion. Compare the risk factors and prevention of pancreatitis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pancreatitis.

3) An older client is diagnosed with chronic pancreatitis. Which information should the nurse include in this client's discharge teaching? **Select all that apply.**
A) Encourage a high-fat diet
B) Eliminate alcoholic beverages
C) Take pancrelipase as prescribed
D) Report symptoms of infection
E) Take antacids
Answer: B, C, D, E
Explanation: A) The client should be taught to follow a low-fat diet.
B) Appropriate teaching for a client diagnosed with chronic pancreatitis includes eliminating alcoholic beverages.
C) Appropriate teaching for a client diagnosed with chronic pancreatitis includes taking pancrelipase as prescribed.
D) The client should report any symptoms of infection (high fever, pain, rapid pulse, malaise).
E) Appropriate teaching for a client diagnosed with chronic pancreatitis includes the importance of taking antacids to prevent the destruction of the enzymes by hydrochloric acid.
Page Ref: 283
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 4.D. Analyze pancreatitis as it relates to digestion. Apply the nursing process in providing culturally competent care to an individual with pancreatitis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pancreatitis.

4) An adult client is admitted to the emergency department with symptoms of acute pancreatitis. Which problems should the nurse identify for this client? **Select all that apply.**

A) Acute pain
B) Impaired swallowing
C) Fluid volume deficiency
D) Nausea
E) Undernutrition

Answer: A, C, D, E

Explanation: A) Acute pancreatitis develops suddenly, typically with an abrupt onset of continuous severe epigastric and abdominal pain.
B) Impaired swallowing is not associated with pancreatitis.
C) Systemic complications of acute pancreatitis include intravascular volume depletion.
D) Other manifestations of acute pancreatitis include nausea and vomiting.
E) Nausea and vomiting can cause imbalanced nutrition.

Page Ref: 285
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Diagnosis

Learning Outcome: 4.D. Analyze pancreatitis as it relates to digestion. Apply the nursing process in providing culturally competent care to an individual with pancreatitis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pancreatitis.

5) An older adult client with a history of alcohol abuse is diagnosed with acute pancreatitis. For which treatment options should the nurse plan when caring for this client? **Select all that apply**.
A) Opioid analgesics
B) High-fat diet
C) Total parenteral nutrition
D) Nasogastric tube to suction
E) Pancrelipase administration
Answer: A, C, D
Explanation: A) Opioid analgesics are often necessary for the acute pain experienced by the client.
B) A client admitted with acute pancreatitis will be NPO until serum amylase levels have returned to normal, bowel sounds are present, and pain disappears.
C) Total parenteral nutrition is initiated.
D) A nasogastric tube is inserted and connected to suction.
E) Pancrelipase is prescribed for clients with chronic pancreatitis, not acute pancreatitis.
Page Ref: 284
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 4.D. Analyze pancreatitis as it relates to digestion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with pancreatitis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pancreatitis.

6) An older client is diagnosed with chronic pancreatitis. Which treatment should the nurse expect to increase the client's risk for edema?
A) Pancrelipase administration
B) IV fluid administration
C) Nasogastric tube insertion
D) Total parenteral nutrition
Answer: B
Explanation: A) Pancrelipase does not increase the risk of edema.
B) Aggressive use of IV fluids to maintain vascular volume is more likely to lead to edema in older adults and may not have the desired effect on renal function.
C) A nasogastric tube will not increase the risk of edema.
D) Total parenteral nutrition will not increase the risk of edema.
Page Ref: 284
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 4.D. Analyze pancreatitis as it relates to digestion. Differentiate care of patients with pancreatitis across the lifespan.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pancreatitis.

7) A client was discharged after hospitalization for acute pancreatitis with instructions on the use of analgesics, cautions on the importance of avoiding alcohol and smoking, and recommendations for a low-fat diet. Which outcomes would indicate that the client has implemented the recommendations? **Select all that apply.**
A) The client experiences reduction or elimination of pain.
B) The client is free from alterations in nutritional status.
C) The client remains free from alterations in fluid balance.
D) The client returns to work.
E) The client is free from nausea.
Answer: A, B, C, E
Explanation: A) Indications that would suggest that the client has implemented the recommendations include a reduction or elimination of pain.
B) Indications that would suggest that the client has implemented the recommendations include freedom from alterations in nutritional status.
C) Indications that would suggest that the client has implemented the recommendations include freedom from alterations in fluid balance.
D) Employment is not an evaluative measure for managing acute pancreatitis.
E) Indications that would suggest that the client has implemented the recommendations include freedom from nausea.
Page Ref: 286
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; information, communication, and education; Physical comfort and emotional support; involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 4.D. Analyze pancreatitis as it relates to digestion. Apply the nursing process in providing culturally competent care to an individual with pancreatitis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pancreatitis.

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8) A 28-year-old pregnant client presents with epigastric pain, back pain, anorexia, nausea, vomiting, and jaundice. Which diagnostic test should the nurse expect to be prescribed to determine the presence of gallstones?

A) Ultrasonography
B) Endoscopic retrograde cholangiopancreatography (ERCP)
C) Contrast-enhanced CT scan
D) Percutaneous fine-needle aspiration biopsy

Answer: A

Explanation: A) Sonography is the imaging method of choice in pregnant clients because it is safe for the fetus and has a high sensitivity to gallstones.
B) An ERCP is not used to diagnose gallstones in a pregnant client.
C) A CT scan with contrast is not used to diagnose gallstones in a pregnant client.
D) A percutaneous fine-needle aspiration biopsy is not used to diagnose gallstones in a pregnant client.

Page Ref: 285

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 4.D. Analyze pancreatitis as it relates to digestion. Differentiate care of patients with pancreatitis across the lifespan.

MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pancreatitis.

9) The nurse is creating a teaching tool about acute pancreatitis. Which characteristic should the nurse emphasize in this tool?
A) The pancreas attacks its own tissue.
B) The pancreas becomes distended with fluid.
C) The pancreas ceases to produce enzymes.
D) The pancreas needs to be removed.
Answer: A
Explanation: A) Regardless of the precipitating factor, the pathophysiologic process of acute pancreatitis begins with the release of activated pancreatic enzymes into pancreatic tissue. Activated proteolytic enzymes, trypsin in particular, digest pancreatic tissue and activate other enzymes such as phospholipase A, which digests cell membrane phospholipids, and elastase, which digests the elastic tissue of blood vessel walls.
B) The problem is not distension of the pancreas with fluid.
C) The problem is not the cessation of enzyme production.
D) The problem is not the pancreas needing to be removed.
Page Ref: 281
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 4.D. Analyze pancreatitis as it relates to digestion. Describe the pathophysiology of pancreatitis.

MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pancreatitis.

Exemplar 4.E Pyloric Stenosis

1) The nurse is providing care to a 1-month-old infant who is brought to the pediatric clinic for projectile vomiting. Which data collected during the assessment process would support the diagnosis of pyloric stenosis? **Select all that apply.**
A) Blood-tinged vomit
B) Low-grade fever
C) Persistent hunger
D) Peristaltic wave
E) Consistent weight gain
Answer: A, C, D
Explanation: A) The vomit can be blood-tinged in pyloric stenosis.
B) A low-grade fever is not expected.
C) Persistent hunger is a symptom of pyloric stenosis.
D) A peristaltic wave occurs in pyloric stenosis.
E) The infant may lose weight due to pyloric stenosis.
Page Ref: 287
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 4.E. Analyze pyloric stenosis as it relates to digestion. Identify the clinical manifestations of pyloric stenosis.

MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pyloric stenosis.

2) A new mother is concerned that a newborn is at risk for pyloric stenosis because the spouse had the condition at birth. Which response should the nurse make?

A) "Your baby has a greater risk for the condition due to a familial history."

B) "Your baby would have an increased risk if the infant was a girl."

C) "Due to your age, your son is at an increased risk for the condition."

D) "As long as your baby has bowel movements there is nothing to worry about."

Answer: A

Explanation: A) The infant is at a greater risk for developing pyloric stenosis because of the familial history.

B) Pyloric stenosis is more common in males than females.

C) The mother's age is not correlated with an increased risk of pyloric stenosis.

D) While bowel movements are important, this is not indicative of not having pyloric stenosis.

Page Ref: 287

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 4.E. Analyze pyloric stenosis as it relates to digestion. Compare the risk factors and prevention of pyloric stenosis.

MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pyloric stenosis.

3) The nurse is caring for an infant who is admitted for possible pyloric stenosis. Which actions will the nurse take when assessing this client? **Select all that apply.**
A) Observe the infant's abdomen.
B) Auscultate bowel sounds.
C) Provide oral feeding.
D) Palpate the right upper quadrant of the abdomen.
E) Pass a nasogastric tube.
Answer: A, B, D
Explanation: A) During the assessment of an infant suspected of having pyloric stenosis, the nurse will observe the infant's abdomen for a peristaltic wave.
B) During the assessment of an infant suspected of having pyloric stenosis, the nurse will auscultate the bowel sounds.
C) Providing oral feedings is not a part of the assessment.
D) During the assessment of an infant suspected of having pyloric stenosis, the nurse will palpate the right upper quadrant of the abdomen for an olive-shaped mass.
E) Inserting a nasogastric tube would not be done during the assessment.
Page Ref: 288
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Client/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 4.E. Analyze pyloric stenosis as it relates to digestion. Apply the nursing process in providing culturally competent care to an individual with pyloric stenosis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pyloric stenosis.

4) The nurse is caring for an infant who is scheduled for surgery for pyloric stenosis. When planning the infant's care, which problems will be noticed? **Select all that apply**.
A) Fluid volume deficiency
B) Hyperbilirubinemia related to poor liver function
C) Sleep disturbance of infant and parents
D) Anxiety in parents
E) Undernutrition
Answer: A, C, D, E
Explanation: A) The client will have a fluid volume deficiency due to poor intake and vomiting.
B) Jaundice is not a clinical manifestation of pyloric stenosis.
C) The client will have a sleep disturbance due to discomfort and hunger.
D) The parents will be anxious because the newborn will have surgery.
E) The client will have undernutrition because of vomiting.
Page Ref: 288
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Client/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Diagnosis
Learning Outcome: 4.E. Analyze pyloric stenosis as it relates to digestion. Apply the nursing process in providing culturally competent care to an individual with pyloric stenosis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pyloric stenosis.

5) The nurse is caring for an infant postsurgery for pyloric stenosis. Which nursing interventions are appropriate when caring for this infant? **Select all that apply.**

A) Administer analgesics, per order.

B) Instruct the parents on proper diapering to avoid pressure over the incision.

C) Encourage swaddling and rocking to facilitate relaxation.

D) Teach the parents to remove the Steri-Strips during the infant's first bath postsurgery.

E) Monitor temperature once per shift.

Answer: A, B, C

Explanation: A) Nursing interventions for an infant postsurgery for pyloric stenosis include administering analgesics as prescribed.

B) The parents should be instructed on diapering to avoid pressure on the incision.

C) The parents should be encouraged to swaddle and rock the infant to aid in relaxation.

D) The parents should be taught to allow the Steri-Strips to come off on their own.

E) The infant's temperature should be monitored every 4 hours due to the increased risk for infection.

Page Ref: 288

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 4.E. Analyze pyloric stenosis as it relates to digestion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with pyloric stenosis.

MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pyloric stenosis.

6) The nurse is providing care to an infant who underwent surgery for pyloric stenosis. Which actions by the nurse will decrease the risk for infection when caring for this infant? **Select all that apply.**
A) Monitor temperature every hour.
B) Place pressure on the incision.
C) Inspect the incision for redness, swelling, or discharge.
D) Auscultate the lungs to assess for any adventitious sounds.
E) Give the infant a tub bath.
Answer: C, D
Explanation: A) The nurse should monitor the infant's temperature every 4 hours.
B) Pressure should be avoided on the incision.
C) The incision should be inspected for redness, swelling, or discharge.
D) The infant's lungs should be auscultated to assess for adventitious breath sounds.
E) The infant should be provided with a sponge bath until the surgical incision has healed.
Page Ref: 288
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 4.E. Analyze pyloric stenosis as it relates to digestion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with pyloric stenosis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pyloric stenosis.

7) The nurse is caring for an infant recovering from a laparoscopic pyloromyotomy. Which statements indicate that teaching provided to the parents about postoperative care were effective? **Select all that apply.**
A) "I will burp my baby every 1-2 ounces during feedings."
B) "It is important to slide the diaper under my baby when changing the diaper."
C) "I will feed my baby 3 times per day."
D) "I will hold my baby in an upright position for 15 minutes after each feeding."
E) "I will clean the incision site with warm, soapy water twice per day."
Answer: A, B
Explanation: A) Appropriate care for an infant after a laparoscopic pyloromyotomy includes burping the infant after every 1-2 ounces of formula.
B) Appropriate care for an infant after a laparoscopic pyloromyotomy includes sliding the diaper under the baby versus pulling on the legs in order to decrease the pressure on the incision site.
C) The baby should be fed on demand, not three times per day.
D) The infant should be held upright for 30 minutes after each feeding.
E) The incision site should be kept clean and dry.
Page Ref: 289
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 4.E. Analyze pyloric stenosis as it relates to digestion. Apply the nursing process in providing culturally competent care to an individual with pyloric stenosis.
MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pyloric stenosis.

8) An adult client is diagnosed with adult pyloric stenosis. Which finding would be unexpected when assessing this client?

A) Weight loss
B) Upper abdominal pain
C) Increase of appetite
D) Nausea

Answer: C

Explanation: A) Symptoms of adult pyloric stenosis include weight loss.
B) Symptoms of adult pyloric stenosis include gradual increase of upper abdominal pain.
C) Symptoms of adult pyloric stenosis include easy satiety and loss of appetite.
D) Nausea and vomiting is common.

Page Ref: 287

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 4.E. Analyze pyloric stenosis as it relates to digestion. Differentiate care of patients with pyloric stenosis across the lifespan.

MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pyloric stenosis.

9) The nurse is reviewing information received during hand-off communication. Which client is most likely to develop adult pyloric stenosis?
A) 11-year-old female client with acute pancreatitis
B) 22-year-old male client with acute hepatitis B
C) 33-year-old female client with GERD
D) 44-year-old male client with gastritis
Answer: D
Explanation: A) An 11-year-old client would not develop an adult form of the condition.
B) Acute hepatitis B is not a risk factor for pyloric stenosis in an adult.
C) Adult pyloric stenosis is more common in male clients.
D) The 44-year-old male client, because of the age, gender, and complaint of gastritis, is the most likely of these clients to develop adult pyloric stenosis. Although adult pyloric stenosis is uncommon, it occurs most commonly in middle-aged men. When it does occur in adults, pyloric stenosis may be classified as primary or secondary. The primary type can occur without an apparent cause. The secondary type is the result of other problems in the GI tract such as ulcer, hernia, a malignancy, or gastritis.
Page Ref: 287
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 4.E. Analyze pyloric stenosis as it relates to digestion. Differentiate care of patients with pyloric stenosis across the lifespan.
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MNL LO: Demonstrate understanding of the concept of digestion in the care of a patient with pyloric stenosis.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 5 Elimination

The Concept of Elimination

1) An older adult reports poor sleep because of the need to void several times during the night. Which statement about the bladder should the nurse make to explain nocturia to this client?
A) "As you get older, there is a decrease in number of nephrons."
B) "As you get older, there is a decrease in the blood supply to your bladder."
C) "As you get older, you may have a decreased bladder capacity."
D) "As you get older, there is a decrease in cardiac output, causing these symptoms."
Answer: C
Explanation: A) A decrease in the number of nephrons in the kidney decreases the filtration rate.
B) Blood flow to the kidney decreases as a result of arteriosclerosis and renal artery atherosclerosis.
C) With aging, the bladder becomes more fibrous, with a consequent decrease in storing capacity and increase in residual urine. The decrease in autonomic regulation of the bladder by the nervous system with aging affects contraction of both the detrusor muscle and the external sphincter.
D) A decrease in cardiac output decreases peripheral circulation, which would decrease urinary output day or night.
Page Ref: 308
Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 5.6. Differentiate considerations related to the assessment and care of patients with alterations in urinary elimination throughout the lifespan.
MNL LO: Analyze the concept of elimination and its application to nursing care.

2) A client with high blood pressure that is not responding to medications is suspected of having renal stenosis. Which location will the nurse auscultate when assessing for this condition?
A) Renal arteries
B) Bladder
C) Ureters
D) Internal urethral sphincter
Answer: A
Explanation: A) The nurse should auscultate the renal arteries by placing the bell of the stethoscope lightly in the areas of the renal arteries, located in the left and right upper abdominal quadrants. Systolic bruits ("whooshing" sounds) may indicate renal artery stenosis.
B) The bladder does not contain the renal arteries.
C) The ureters are not the locations to assess for renal stenosis.
D) The internal urethral sphincter is not the location to assess for renal stenosis.
Page Ref: 302
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.1. Analyze the physiology of urinary elimination in the body.
MNL LO: Analyze the concept of elimination and its application to nursing care.

3) The nurse is caring for a group of clients on a medical-surgical unit. Which client should the nurse anticipate to be at the greatest risk for alterations in urinary elimination?
A) The client with hypertension who takes a diuretic to manage blood pressure
B) An 80-year-old male client reporting frequent urination at night
C) A 25-year-old female client with low self-esteem
D) A client who had bladder cancer and now has a newly created ileal conduit
Answer: B
Explanation: A) The client with high blood pressure takes medication to remove excess fluid from the body, and as long as urine elimination increases, there should be no problems.
B) The client who is 80 years old with frequent urination at night may be having problems with his prostate. Older male adults experience urinary retention due to prostate enlargement, causing an alteration in urinary elimination.
C) The 25-year-old experiencing low self-esteem has a psychological problem and will need therapy to find the root of the problem.
D) The client who had bladder cancer and now has an ileal conduit doesn't have kidney damage, only the bladder removed. Continued urine production through the ileal conduit will need to be observed and assessed frequently by the staff.
Page Ref: 295
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.6. Differentiate considerations related to the assessment and care of patients with alterations in urinary elimination throughout the lifespan.
MNL LO: Analyze the concept of elimination and its application to nursing care.

4) The nurse is caring for a client with a history of urinary tract infections (UTIs). Which action should the nurse take to help decrease the risk of the client experiencing future UTIs?
A) Instruct the client to avoid delaying urination.
B) Tell the client to increase caffeine in the diet.
C) Encourage the client to use the pelvic floor muscles to force urine flow.
D) Remind the client to wipe from back to front.
Answer: A
Explanation: A) Suppressing urination increases the risk of urinary tract infections.
B) The client should decrease the use of caffeine in the diet because caffeine is a bladder irritant.
C) The pelvic floor muscles should not be used to force urine flow and doing so is considered a poor toileting habit.
D) The client should wipe from front to back because wiping from back to front would contaminate the urinary meatus.
Page Ref: 295
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 5.2. Differentiate alterations in urinary elimination.
MNL LO: Analyze the concept of elimination and its application to nursing care.

5) The nurse admits a client to the medical unit for a urinary disorder. Which questions should the nurse ask when assessing the client's voiding pattern? **Select all that apply.**

A) How many times do you urinate in a 24-hour period?
B) Has your pattern of urination changed recently?
C) How often do you get out of bed at night to urinate?
D) What color is your urine?
E) Does your urine have any type of odor?

Answer: A, B, C

Explanation: A) When assessing the client's voiding pattern, it is appropriate for the nurse to ask how many times the client voids in a 24-hour period.
B) When assessing the client's voiding pattern, it is appropriate for the nurse to ask if the pattern of urination has changed recently.
C) When assessing the client's voiding pattern, it is appropriate for the nurse to ask how often the client gets out of bed at night to urinate.
D) Questions regarding the color of urine is appropriate when assessing urine characteristics.
E) Questions regarding the odor of urine is appropriate when assessing urine characteristics.

Page Ref: 297
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 5.3. Differentiate common assessment procedures and tests used to examine urinary elimination.
MNL LO: Analyze the concept of elimination and its application to nursing care.

6) The nurse suspects a client has a urinary tract infection. Which urinalysis result supports the nurse's suspicions?
A) pH 5.2
B) Negative glucose
C) WBC 10-15
D) Specific gravity 1.012
Answer: C
Explanation: A) The pH is between 4.5 and 8.
B) There should be no glucose in the urine.
C) A normal WBC is 3-4. The WBC count for this client is high and indicates infection.
D) The specific gravity should be between 1.005 and 1.030.
Page Ref: 300
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.3. Differentiate common assessment procedures and tests used to examine urinary elimination.
MNL LO: Analyze the concept of elimination and its application to nursing care.

7) The nurse is providing care to a client who is experiencing urinary incontinence. Which independent nursing intervention is the most appropriate for this client?
A) Encouraging increased fluid intake
B) Providing catheter care
C) Instructing on self-catheterization
D) Teaching hygiene care
Answer: D
Explanation: A) Encouraging increased fluid intake is appropriate for a client who is dehydrated.
B) Providing catheter care is appropriate for a client who is diagnosed with urinary retention.
C) Instructing on self-catheterization is appropriate for a client who is diagnosed with urinary retention.
D) Clients with urinary incontinence must be taught hygiene care–sometimes called incontinence care–to protect against tissue breakdown.
Page Ref: 303
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.8 Promote self-care management. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 5.4. Analyze independent interventions nurses can implement for patients with alterations in urinary elimination.
MNL LO: Analyze the concept of elimination and its application to nursing care.

8) The nurse is assigned to a postpartum client who had an anesthetic block during labor and delivery. When providing care for this client, which should the nurse anticipate?
A) Nocturnal enuresis
B) Risk for hyperkalemia
C) Residual urine
D) Glycosuria
Answer: C
Explanation: A) Nocturnal enuresis would be anticipated for older adult clients.
B) Risk for hyperkalemia would be anticipated for older adult clients.
C) The postpartum woman is at risk for overdistention, incomplete bladder emptying, and buildup of residual urine (urine that remains in the bladder after voiding).
D) Glycosuria is expected for a client during pregnancy, not during the postpartum period.
Page Ref: 307
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 5.6. Differentiate considerations related to the assessment and care of patients with alterations in urinary elimination throughout the lifespan.
MNL LO: Analyze the concept of elimination and its application to nursing care.

9) A client with urinary urgency is prescribed an anticholinergic medication. Which teaching should the nurse provide to this client?

A) "This medication must be taken on an empty stomach."

B) "You will need to discontinue the medication when your symptoms subside."

C) "This medication causes constipation. You should take a laxative every day."

D) "It is important to notify the healthcare provider if you experience urinary retention."

Answer: D

Explanation: A) There is no specific information regarding if this medication needs to be taken on an empty stomach.

B) Clients should always check with their healthcare provider before stopping any medication, because there could be some major complications

C) Constipation has been reported but a laxative should not be taken every day, as one can become dependent.

D) Anticholinergics can cause urinary retention; therefore, it would be important for the client to notify the healthcare provider if this occurs.

Page Ref: 304

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 5.5. Summarize collaborative therapies used by interprofessional teams for patients with alterations in urinary elimination.

MNL LO: Analyze the concept of elimination and its application to nursing care.

10) The nurse is providing care to a client who is experiencing urinary retention. Which diagnostic tool should the nurse anticipate being ordered for this client?
A) Ultrasonic bladder scan
B) Urinalysis
C) Intravenous pyelography (IVP)
D) Cystoscopy
Answer: A
Explanation: A) An ultrasonic bladder scan is the diagnostic test that is used to examine for residual urine.
B) A urinalysis is often used to monitor the urine for infection.
C) An IVP is used to diagnosis a kidney stone.
D) A cystoscopy allows direct visualization of the bladder wall and urethra. It is often used to remove stones.
Page Ref: 299
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 5.3. Differentiate common assessment procedures and tests used to examine urinary elimination.
MNL LO: Analyze the concept of elimination and its application to nursing care.

11) The nurse is conducting education regarding urinary health at an assisted living facility. Which topics should the nurse include for this population? **Select all that apply.**
A) Full urinary control usually occurs at 4 or 5 years of age.
B) Due to neuromuscular immaturity in infancy, voluntary urinary control is absent.
C) The kidneys reach maximum size between 35 and 40 years of age.
D) Renal blood flow decreases because of vascular changes and a decrease in cardiac output.
E) Urinary incontinence may occur because of mobility problems or neurological impairments.
Answer: D, E
Explanation: A) Full urinary control is not an appropriate topic for an older population.
B) Neuromuscular maturity in infancy is not an appropriate topic for an older population.
C) Size of the kidneys is not an appropriate topic for an older population.
D) When planning an education session regarding urinary health at an assisted living facility, the nurse would include information that affects the urinary health of the older adult client. Information that is appropriate for the nurse to consider is the decrease in renal blood flow due to vascular changes.
E) When planning an education session regarding urinary health at an assisted living facility, the nurse would include information that affects the urinary health of the older adult client. Information that is appropriate for the nurse to consider is that urinary incontinence may occur because of issues with mobility and neurological impairment.
Page Ref: 308
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 5.6. Differentiate considerations related to the assessment and care of patients with alterations in urinary elimination throughout the lifespan.
MNL LO: Analyze the concept of elimination and its application to nursing care.

12) The nurse is providing care to newborns in the nursery. When assessing the newborns' urinary output, which should the nurse anticipate as normal daily urinary output?
A) 15-60 mL
B) 100-300 mL
C) 250-450 mL
D) 400-500 mL
Answer: A
Explanation: A) Normal urinary output for the newborn at 1-2 days of age is 15-60 mL per day.
B) Normal urinary output for a newborn 3 to 10 days of age is 100-300 mL per day.
C) The normal output for the newborn at 10 days of age to the infant at 2 months of age is 250-400 mL per day.
D) Normal output for an infant at 2 months of age through 1 year is 400-500 mL per day.
Page Ref: 307
Cognitive Level: Remembering
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.6. Differentiate considerations related to the assessment and care of patients with alterations in urinary elimination throughout the lifespan.
MNL LO: Analyze the concept of elimination and its application to nursing care.

13) The nurse is observing a graduate nurse assess a client's abdomen. For which actions should the nurse intervene? **Select all that apply.**
A) Performing palpation before auscultation
B) Performing auscultation before palpation
C) Using inspection, auscultation, percussion, and palpation during the abdominal assessment of the client
D) Using only inspection, percussion, and palpation during the abdominal assessment of the client
E) Using deep palpation during the assessment process
Answer: A, D, E
Explanation: A) Auscultation should precede palpation, because palpation can alter peristalsis.
B) Auscultation should precede palpation, because palpation can alter peristalsis.
C) Physical examination of the abdomen includes inspection, auscultation, percussion, and palpation.
D) Physical examination of the abdomen includes inspection, auscultation, percussion, and palpation.
E) Never use deep palpation on a client who has an abdominal mass, renal transplant, or polycystic kidneys, or who is at risk for hemorrhage.
Page Ref: 315
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 5.9. Differentiate common assessment procedures and tests used to examine bowel elimination.
MNL LO: Analyze the concept of elimination and its application to nursing care.

14) The client is experiencing urinary urgency and frequency. Which medication should the nurse anticipate being prescribed by the healthcare provider?
A) Furosemide
B) Bumetanide
C) Oxybutynin
D) Bethanechol chloride
Answer: C
Explanation: A) Furosemide is a diuretic and works in a specific place within the nephron to increase fluid excretion and prevent fluid reabsorption.
B) Bumetanide is a diuretic and works in a specific place within the nephron to increase fluid excretion and prevent fluid reabsorption.
C) Oxybutynin is an anticholinergic that reduces urgency and frequency by blocking muscarinic receptors in the detrusor muscle of the bladder, thereby inhibiting contractions and increasing storage capacity.
D) Bethanechol chloride is a cholinergic agent that stimulates bladder contraction and facilitates voiding.
Page Ref: 304
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 5.5. Summarize collaborative therapies used by interprofessional teams for patients with alterations in urinary elimination.
MNL LO: Analyze the concept of elimination and its application to nursing care.

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15) The nurse is asked to explain the effect on stool when fluid intake is less than adequate. Which response will the nurse make?

A) It is drier and harder than normal.
B) It is more watery and more soft than normal.
C) It is more watery and harder than normal.
D) It is drier and more soft than normal.

Answer: A

Explanation: A) When fluid intake is inadequate or output is excessive, the passage of chyme slows and the absorption of fluid increases. The end result is feces that is harder and drier than normal.

B) Watery, soft feces is the result of rapid intestinal transit that leads to inadequate fluid absorption.

C) Watery and hard stool would not occur when fluid intake is inadequate.

D) Dry and soft stool would not occur when fluid is inadequate.

Page Ref: 309

Cognitive Level: Remembering

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 5.7. Analyze the physiology of bowel elimination in the body.

MNL LO: Analyze the concept of elimination and its application to nursing care.

16) Clients experiencing diarrhea often lose electrolytes. Which statement describes the reason for this loss?
A) Decreased secretion of intestinal mucus inhibits the absorption of electrolytes from the chyme by the intestine.
B) Pathogenic microorganisms that cause diarrhea consume the electrolytes in the chyme, resulting in fewer electrolytes being available for absorption.
C) Diarrhea causes rapid passage of chyme through the large intestine, reducing the time available for absorption of electrolytes.
D) Intestinal bacteria break down electrolytes during diarrhea and make them unfit for absorption by the intestine.
Answer: C
Explanation: A) Diarrhea typically increases secretion of intestinal mucus rather than decreasing it.
B) Pathogenic microorganisms result in inflammation of the mucosa.
C) Diarrhea causes rapid passage of chyme through the large intestine. This reduces the time available for the large intestine to absorb electrolytes and results in the electrolytes being lost with feces.
D) Bacteria in the intestine cannot break down electrolytes.
Page Ref: 310
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.8. Differentiate alterations in bowel elimination.
MNL LO: Analyze the concept of elimination and its application to nursing care.

17) A client presents in the emergency department exhibiting signs indicative of the onset of a bowel obstruction. Which bowel sounds should the nurse anticipate when auscultating the client's abdomen?

A) Gurgling or clicking sounds
B) High-pitched tinkling, rushing, or growling sounds
C) Absence of sounds
D) Continuous, medium-pitched hum

Answer: B

Explanation: A) Gurgling or clicking sounds are considered normal.

B) High-pitched tinkling, rushing, or growling bowel sounds–known as borborygmus–are indicative of the onset of bowel obstruction.

C) Absence of bowel sounds is indicative of late bowel obstruction, not onset of bowel obstruction.

D) A continuous, medium pitched hum–called a venous hum–is indicative of a cirrhotic liver.

Page Ref: 315

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 5.9. Differentiate common assessment procedures and tests used to examine bowel elimination.

MNL LO: Analyze the concept of elimination and its application to nursing care.

18) A client presents with constipation even though using the abdominal muscles to aid with defecation. Which response should the nurse make?

A) "Try taking an over-the-counter medication containing bismuth salts, such as Kaopectate or Pepto-Bismol. If your symptoms don't subside in 2 days, come back to the office."

B) "Stop taking all medications until you have reestablished a normal elimination routine. Medication usage often leads to constipation."

C) "Make sure that you are taking proper care of the skin in the anal area. Skin breakdown can result in hesitancy when defecating."

D) "Try to avoid straining with the abdominal muscles during defecation. Doing so may actually close the anal sphincter, preventing feces from passing through."

Answer: D

Explanation: A) Bismuth salts are antidiarrheals–not laxatives–and would likely compound the client's problem.

B) Certain medications can lead to constipation in some clients, but it is not appropriate for the nurse to encourage the discontinuation of all medications.

C) Skin care is a concern for clients who are experiencing diarrhea or fecal incontinence and is not typically an issue for patients with constipation.

D) Clients should be instructed to use caution when straining the abdominal muscles during defecation, because it may close the anal sphincter rather than allowing feces to pass through.

Page Ref: 310, 313

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 5.10. Analyze independent interventions nurses can implement for patients with alterations in bowel elimination.

MNL LO: Analyze the concept of elimination and its application to nursing care.

19) The nurse is preparing to assess clients in the clinic experiencing problems with bowel elimination. Which client is most likely to have a daily stool softener added to the treatment regimen?
A) A 3-month-old client who is exclusively breastfed
B) A 43-year-old client who takes opioid medication for chronic pain
C) A 92-year-old client who experiences frequent leakage of feces from the anus
D) A 28-year-old client who is anemic and has blood in the stool
Answer: B
Explanation: A) Breastfed infants typically have soft, liquid stools and would not benefit from a stool softener.
B) Clients taking opioids have an increased risk of developing constipation and may prevent it by taking daily stool softeners.
C) Leakage of feces from the anus is indicative of bowel incontinence–not constipation–and would not be treated with a stool softener.
D) Anemia and blood in the stool are indicators of potential bowel cancer or other serious conditions; this client would likely undergo testing rather than be prescribed a stool softener.
Page Ref: 319
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.11. Summarize collaborative therapies used by interprofessional teams for patients with alterations in bowel elimination.
MNL LO: Analyze the concept of elimination and its application to nursing care.

Exemplar 5.A Benign Prostatic Hyperplasia

1) The nurse is caring for a client diagnosed with benign prostatic hyperplasia (BPH) who is experiencing an increase in symptoms. Which statement by the client would best explain the source of the increased symptoms?
A) "I have decreased oral intake at night."
B) "I recently had a vasectomy."
C) "I am using an over-the-counter cold medication for a cold."
D) "I am drinking very little caffeine."
Answer: C
Explanation: A) Decreasing oral intake at night may resolve symptoms.
B) A vasectomy does not affect the symptoms of BPH.
C) Use of cold medications can increase symptoms because of their anticholinergic properties.
D) Avoiding caffeine may resolve symptoms.
Page Ref: 327
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.A. Analyze benign prostatic hyperplasia (BPH) as it relates to elimination. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with BPH.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

2) The nurse is providing care to a client who is diagnosed with benign prostatic hyperplasia (BPH). Which information in the client's health history indicate a risk factor for this diagnosis? **Select all that apply.**
A) Excessive exercise
B) Decreased fluid intake
C) Diet high in milk
D) 70 years of age
E) African American ethnicity
Answer: D, E
Explanation: A) Excessive exercise does not cause BPH.
B) Decreasing oral intake does not cause BPH.
C) A diet high in milk does not cause BPH.
D) Although the exact cause is unknown, risk factors associated with BPH include increasing age.
E) The prevalence of BPH is similar in African American and white men, but it tends to be more severe and progressive in African American men.
Page Ref: 325
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.A. Analyze benign prostatic hyperplasia (BPH) as it relates to elimination. Compare the risk factors and prevention of BPH.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

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3) A middle-aged male client who is experiencing urinary retention is experiencing symptoms of benign prostatic hyperplasia (BPH). Which information in the client's history should the nurse identify as a modifiable risk factor?
A) BMI 35
B) Plays tennis
C) Takes aspirin
D) Works full-time
Answer: A
Explanation: A) Obesity is a modified risk factor for BPH.
B) An active lifestyle is not a risk factor for BPH.
C) Taking aspirin is not a risk factor for BPH.
D) No specific employment is identified for the development of BPH.
Page Ref: 325
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 5.A. Analyze benign prostatic hyperplasia (BPH) as it relates to elimination. Compare the risk factors and prevention of BPH.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

4) The nurse is providing follow-up care for a client recently diagnosed with benign prostatic hyperplasia (BPH). Which problem should the nurse use to guide this client's plan of care?
A) Chronic pain
B) Impaired urinary function
C) Constipation
D) Diarrhea
Answer: B
Explanation: A) The client with BPH will experience acute pain.
B) The priority problem for a client diagnosed with BPH is impaired urinary function.
C) Clients with BPH have problems associated with urinary elimination, not bowel elimination.
D) Clients with BPH have problems associated with urinary elimination, not bowel elimination.
Page Ref: 329
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 5.A. Analyze benign prostatic hyperplasia. Apply the nursing process in providing culturally competent care to an individual with BPH.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

5) A client recovering from prostate surgery will be ready for discharge within the next few days. Which teaching point should the nurse focus on for this client?

A) The client should not drive for 6 weeks after surgery.

B) The client should call the healthcare provider immediately for any bleeding.

C) The client should increase the intake of water.

D) The client should avoid heavy lifting for 2 weeks after surgery.

Answer: C

Explanation: A) The client may not drive for 2 weeks after surgery.

B) The client is instructed to call the doctor for heavy bleeding, though minor bleeding when defecating, coughing, or exercising is normal.

C) The client should be encouraged to increase fluids to 8, 10 ounce glasses each day.

D) The client is taught to avoid heavy lifting for 4-8 weeks after discharge.

Page Ref: 332

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 5.A. Analyze benign prostatic hyperplasia (BPH) as it relates to elimination. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with BPH.

MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

6) A client is recovering from minimally invasive surgery to treat benign prostatic hyperplasia (BPH). After assessing the client, the nurse expects which outcome for this client?
A) Bowel continence
B) Absence of pain
C) No postoperative treatment
D) Urinary continence
Answer: D
Explanation: A) Most clients, due to pain and swelling in the area, may have problems with constipation immediately following the surgical intervention.
B) The client will experience some amount of discomfort after the procedure.
C) The client will need postoperative teaching.
D) After surgery and removal of the catheter, the client should return to urinary continence as expected.
Page Ref: 328
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 5.A. Analyze benign prostatic hyperplasia. Apply the nursing process in providing culturally competent care to an individual with BPH.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

7) The nurse is providing care to a client who is diagnosed with mild benign prostatic hyperplasia (BPH). Which lifestyle change is appropriate for this client?
A) Increasing caffeine intake
B) Increasing alcohol intake
C) Perform pelvic floor exercises
D) Using over-the-counter antihistamines
Answer: C
Explanation: A) The client should eliminate caffeine from the diet.
B) The client should eliminate alcohol from the diet.
C) A client who is diagnosed with mild BPH should be instructed to perform pelvic floor exercises.
D) The client should avoid using over-the-counter antihistamines.
Page Ref: 327
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.8 Promote self-care management. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 5.A. Analyze benign prostatic hyperplasia (BPH) as it relates to elimination. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with BPH.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

8) The nurse instructs a client about the new diagnosis of benign prostatic hyperplasia (BPH). Which statement indicates to the nurse that the client needs further education?
A) "Alpha blockers can be used to control my symptoms."
B) "I know I will get cancer of the prostate because of this."
C) "As my condition progresses, I may need to consider surgical management."
D) "There are nonsurgical treatment options available."
Answer: B
Explanation: A) Alpha blockers will help control the symptoms.
B) BPH is a benign condition that is not considered a precursor to cancer. It is caused by an increase in size of the prostate gland and is seen in older males.
C) Surgery can be done to manage the condition.
D) There are nonsurgical treatments available, such as medication to shrink the gland.
Page Ref: 326
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 5.A. Analyze benign prostatic hyperplasia (BPH) as it relates to elimination. Apply the nursing process in providing culturally competent care to an individual with BPH.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

9) A client is diagnosed with benign prostatic hyperplasia (BPH). Which topics are appropriate for the nurse to include in the teaching session related to the client's condition? **Select all that apply.**
A) Self-care
B) Nutrition
C) Surgical approaches to treatment
D) Pharmacologic approaches to treatment
E) Permanent urinary catheterization
Answer: A, B, C, D
Explanation: A) When conducting teaching for a client who is diagnosed with BPH, the nurse will include information regarding self-care.
B) When conducting teaching for a client who is diagnosed with BPH, the nurse will include information regarding nutrition.
C) When conducting teaching for a client who is diagnosed with BPH, the nurse will include information regarding surgical approaches for treatment.
D) When conducting teaching for a client who is diagnosed with BPH, the nurse will include information regarding pharmacologic approaches for treatment.
E) Permanent urinary catheterization is not an appropriate topic to include in the teaching session.
Page Ref: 330
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 5.A. Analyze benign prostatic hyperplasia (BPH) as it relates to elimination. Apply the nursing process in providing culturally competent care to an individual with BPH.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

10) A client is concerned about developing benign prostatic hyperplasia (BPH). Which information in the client's history increases the risk for this condition?
A) Increased levels of testosterone
B) Increased levels of estrogen
C) 35 years of age
D) Circumcision at birth
Answer: B
Explanation: A) Elevated levels of testosterone prevent the development of BPH.
B) Clients with increased levels of estrogen are at an increased risk for developing BPH.
C) Clients younger than 40 years of age are at a decreased risk for BPH.
D) Circumcision does not impact the development of BPH.
Page Ref: 325
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.A. Analyze benign prostatic hyperplasia (BPH) as it relates to elimination. Compare the risk factors and prevention of BPH.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

11) The client admitted with benign prostatic hyperplasia (BPH) is prescribed an alpha-adrenergic blocker as treatment. When providing care to this client, which assessment is a priority related to this medication?
A) Blood pressure
B) Pain rating
C) Respiratory rate
D) Temperature
Answer: A
Explanation: A) Alpha-adrenergic blockers may cause first-dose phenomenon (severe hypotension and syncope) and tachycardia. When administering this medication to a client diagnosed with BPH, the priority assessment is the client's blood pressure.
B) Pain level is not a priority to assess for an alpha-adrenergic blocker.
C) Respiratory rate is not a priority to assess for an alpha-adrenergic blocker.
D) Temperature is not a priority to assess for an alpha-adrenergic blocker.
Page Ref: 328
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | Nursing Process: Assessment
Learning Outcome: 5.A. Analyze benign prostatic hyperplasia (BPH) as it relates to elimination. Summarize the diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with BPH.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

12) The nurse is planning care for a client with mild benign prostatic hyperplasia (BPH) who is experiencing urinary retention. Which goal is the most appropriate for this client?
A) The client will increase fluid intake to at least 2-3 liters daily.
B) The client lists over-the-counter medications to be avoided.
C) The client will voice an understanding of the importance of the use of antiembolic stockings and compression devices.
D) The client will use a T-binder or scrotal support properly.
Answer: B
Explanation: A) An increased fluid intake can assist in preventing burning on urination after catheter removal and reduces the risk of a urinary tract infection. There is no indication that this client had surgery or had a catheter placed.
B) Avoiding over-the-counter medications can lessen or prevent the symptoms associated with mild benign prostatic hyperplasia (BPH).
C) The use of antiembolic stockings and compression devices reduces the risk of developing a thromboembolism. There is no indication that this client had surgery or is at risk for developing a thromboembolism.
D) The use of a T-binder or scrotal support is for those clients that have undergone surgery and are in need of scrotal support and support of the surgical dressing. There is no indication that this client had surgery or had a catheter placed.
Page Ref: 329
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 5.A. Analyze benign prostatic hyperplasia (BPH) as it relates to elimination. Apply the nursing process in providing culturally competent care to an individual with BPH.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

13) A client with benign prostatic hyperplasia (BPH) experiences burning and difficulty when urinating. Based on this data, which problem is the priority for this client?
A) Potential for bleeding
B) Potential for fluid volume imbalance
C) Acute pain
D) Lack of knowledge
Answer: C
Explanation: A) There is no evidence the client is bleeding.
B) There is no evidence of a fluid volume imbalance.
C) The client is experiencing burning and other difficulties during urination. The burning indicates the client is experiencing pain and would indicate a problem of acute pain.
D) There is no evidence that the client lacks knowledge about the condition.
Page Ref: 329
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 5.A. Analyze benign prostatic hyperplasia (BPH) as it relates to elimination. Apply the nursing process in providing culturally competent care to an individual with BPH.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

14) The nurse is preparing a teaching tool about the pathophysiology of benign prostatic hyperplasia (BPH). Which statement should the nurse include that describes why benign prostatic hyperplasia is more common in older men than in younger men?
A) An increase in androgen production occurs with age, and increased androgens trigger prostatic growth.
B) Hyperplasia of stromal and epithelial cells in the prostate gland occurs over a long period of time.
C) A decrease in estrogen levels occurs over time and results in an increase in the size of the individual cells within the prostate.
D) Frequency of urinary tract infections increases with age, and frequent UTIs contribute to changes in the prostate.
Answer: B
Explanation: A) As men age, androgen production decreases rather than increases.
B) Hyperplasia is an increase in the number of cells; in the case of BPH, hyperplasia occurs in the cells of the prostate over a long period of time.
C) Estrogen levels increase with age rather than decreasing.
D) UTIs are often a result rather than a cause of BPH.
Page Ref: 325
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 5.A. Analyze benign prostatic hyperplasia (BPH) as it relates to elimination. Describe the pathophysiology of BPH.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

15) A client with BPH is experiencing urinary retention and bladder distention. Which action should the nurse anticipate to reduce the client's risk of developing diverticula, hydroureter, and hydronephrosis?
A) The enlarging mass of prostatic tissue must be reduced.
B) Straining during urination must be avoided.
C) Bladder pain must be managed.
D) The weak urinary stream must be strengthened.
Answer: A
Explanation: A) The enlarging mass contributes to distention of the bladder, so this is the most important issue to address to avoid diverticula, hydroureter, and hydronephrosis.
B) Straining during urination is associated with voiding rather than urinary retention and is less critical to avoiding complications.
C) Bladder pain is associated with storage rather than retention and should be addressed but is not critical to avoiding complications.
D) A weak stream is associated with voiding rather than urinary retention and is less critical to avoiding complications.
Page Ref: 326
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 5.A. Analyze benign prostatic hyperplasia (BPH) as it relates to elimination. Identify the clinical manifestations of BPH.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with benign prostatic hyperplasia.

Exemplar 5.B Bladder Incontinence and Retention

1) The nurse is providing care to a client who is diagnosed with stress incontinence. Which data would the nurse expect to collect during the client's health history and physical assessment? **Select all that apply**.
A) Urine leakage while talking
B) Urine leakage while coughing
C) Urine leakage while sneezing
D) Skin breakdown on the buttock
E) A urinary catheter
Answer: B, C, D
Explanation: A) Stress incontinence would not be caused by talking.
B) Stress incontinence involves a small leakage of urine when a client coughs.
C) Stress incontinence involves a small leakage of urine when a client sneezes.
D) If the client has been experiencing incontinence, the nurse might expect to see the skin inflamed and irritated because urine is very irritating to the skin.
E) A urinary catheter is not an expected finding.
Page Ref: 335
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.B. Analyze bladder incontinence and retention as they relate to elimination. Describe the etiology of bladder incontinence and retention.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bladder incontinence and retention.

2) The nurse conducts education for a client who is experiencing urinary incontinence. Which statement by the client indicates the need for further education?
A) "Relaxation of pelvic muscles may be a factor in incontinence."
B) "Reduced urethral resistance can be a cause of incontinence."
C) "Incontinence is normal with aging."
D) "A disturbance of my bladder is a factor in the development of incontinence."
Answer: C
Explanation: A) Relaxation of the pelvic muscles is a potential factor in the development of incontinence.
B) Reduced urethral resistance is a potential factor in the development of incontinence.
C) Age is a risk factor for incontinence, but incontinence is not a normal result of aging.
D) A disturbance is a potential factor in the development of incontinence.
Page Ref: 334
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 5.B. Analyze bladder incontinence and retention as they relate to elimination. Compare the risk factors and prevention of bladder incontinence and retention.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bladder incontinence and retention.

3) The nurse is caring for a client with urinary incontinence. Which information should the nurse include when instructing on bladder training?
A) Keep a bladder diary.
B) Plan to void every 6 hours.
C) Delay voiding when the urge occurs.
D) Avoid Kegel exercises when the urge occurs.
Answer: A
Explanation: A) Bladder training requires the client to postpone urination. The goal is to gradually lengthen the interval between voiding. The client should be instructed to keep a bladder diary to document the time, amount, leakage, or feelings of urgency.
B) For bladder training, the time should be gradually increased to 3 to 4 hours and not begin at 6 hours.
C) Voiding should not be delayed when the urge occurs.
D) Kegel exercises should be done when the urge occurs.
Page Ref: 338
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 5.B. Analyze bladder incontinence and retention as they relate to elimination. Apply the nursing process in providing culturally competent care to an individual with bladder incontinence or retention.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bladder incontinence and retention.

4) A client has a problem of stress incontinence. Which outcome should the nurse plan for this client?

A) The client will stop the flow of urine when voiding.

B) The client will improve incontinence within 1 month.

C) The client will empty the bladder every time she voids.

D) The client will verbalize procedure for Kegel exercises.

Answer: D

Explanation: A) Clients are not instructed to stop the flow of urine when voiding, because this could lead to retention.

B) Improved continence takes 3-6 months, so 1 month is not a realistic goal.

C) Emptying the bladder completely every time voiding occurs would not be realistic in the beginning. This will take time.

D) Verbalizing the procedure for Kegel exercises is an appropriate goal for stress incontinence.

Page Ref: 343

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 5.B. Analyze bladder incontinence and retention as they relate to elimination. Apply the nursing process in providing culturally competent care to an individual with bladder incontinence or retention.

MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bladder incontinence and retention.

5) A client has a history of chronic urinary tract infections. Which treatment should the nurse anticipate for the problem of urinary retention because of scarring?
A) Antibiotic therapy
B) An anticholinergic medication
C) Intermittent straight catheterization
D) Removal of bladder stones
Answer: C
Explanation: A) Antibiotic therapy is not indicated, as the client does not have an infection now.
B) Anticholinergic medications can cause urinary retention.
C) The healthcare provider may order straight catheterization so the client can be taught to self-catheterize and manage the urinary retention at home.
D) Bladder stones are not the problem; scarring is.
Page Ref: 341
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 5.B. Analyze bladder incontinence and retention as they relate to elimination. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with bladder incontinence or retention.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bladder incontinence and retention.

6) An older client reports urinary "accidents" and expresses frustration about this "normal part of aging." Which response should the nurse make?
A) "Tell me more about the incontinence you are experiencing."
B) "You may need to have surgery to manage this problem."
C) "I understand you are frustrated about this occurrence."
D) "Unfortunately, aging and incontinence go hand in hand."
Answer: A
Explanation: A) As the body ages, there are anatomic changes that can increase the risk for urinary incontinence; however, this is not a normal part of aging. It is appropriate for the nurse to gather more information regarding the client's incontinence.
B) It is beyond the nurse's scope of practice to recommend surgery to the client.
C) Telling the client that the nurse understands does not help to determine the cause of the client's incontinence.
D) Incontinence is not an accepted part of aging.
Page Ref: 342
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 5.B. Analyze bladder incontinence and retention as they relate to elimination. Compare risk factors and prevention of bladder incontinence and retention.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bladder incontinence and retention.

7) The nurse is providing training for the clinical staff of a skilled care facility that primarily treats elderly clients. Which risk factors for functional incontinence will the nurse include in the training? **Select all that apply.**

A) Limited mobility
B) Impaired vision
C) Lack of access to facilities
D) Dementia
E) Urinary tract infection

Answer: A, B, C, D

Explanation: A) An immobilized client may experience incontinence if a call light is not within reach.
B) A client with impaired vision may not be able to find the bathroom.
C) Minimal facilities can create problems in urinary control.
D) A client with Alzheimer disease, along with other forms of dementia, may perceive the urge to void but be unable to interpret its meaning or respond by seeking a bathroom.
E) Urinary tract infection is not usually related to functional incontinence.

Page Ref: 336
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 5.B. Analyze bladder incontinence and retention as they relate to elimination. Differentiate care of patients with bladder incontinence and retention across the lifespan.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bladder incontinence and retention.

8) The nurse is caring for a client with functional incontinence. Which conditions are factors in the development of this type of incontinence? **Select all that apply.**

A) Fecal impaction
B) Dementia
C) Confusion
D) Prostate surgery
E) Impaired mobility

Answer: B, C, E

Explanation: A) Fecal impaction is a contributing factor to overflow incontinence.

B) Functional incontinence occurs when the ability to respond to the need to urinate is impaired. Contributing factors may include dementia.

C) Functional incontinence occurs when the ability to respond to the need to urinate is impaired. Contributing factors may include confusion.

D) Prostate surgery is a contributing factor to stress incontinence.

E) Functional incontinence occurs when the ability to respond to the need to urinate is impaired. Contributing factors may include impaired mobility.

Page Ref: 336

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 5.B. Analyze urinary incontinence and retention as they relate to elimination. Describe the etiology of bladder incontinence and retention.

MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bladder incontinence and retention.

9) The nurse is reviewing discharge instructions for a client diagnosed with urinary incontinence. Which statement made by the client indicates the need for further education?
A) "I should drink plenty of water."
B) "I will avoid alcohol and coffee."
C) "I will get regular exercise."
D) "I will continue to hold my urine while in public."
Answer: D
Explanation: A) A client who is diagnosed with urinary should drink plenty of water spaced throughout the day to prevent urinary incontinence.
B) A client who is diagnosed with urinary incontinence should be instructed to avoid alcohol and caffeine.
C) A client who is diagnosed with urinary should be instructed to get regular exercise.
D) A client who is diagnosed with urinary incontinence should not hold the urine but rather empty the bladder when the urge occurs.
Page Ref: 335
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 5.B. Analyze bladder incontinence and retention as they relate to elimination. Apply the nursing process in providing culturally competent care to an individual with bladder incontinence or retention.

MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bladder incontinence and retention.

10) The nurse is inserting an indwelling urinary catheter into an older adult male with an enlarged prostate. Which action should the nurse alter when inserting the catheter?
A) Injects 10 mL of 2% lidocaine gel into the client's urethra.
B) Inserts a 16 French coudé-tipped catheter.
C) Uses sterile technique to place the catheter.
D) Tapes the catheter to the leg
Answer: D
Explanation: A) Using 2% lidocaine gel 10 mL injected into the male urethra reduces discomfort during catheterization and the risk of catheter-associated infection, and it promotes pelvic muscle relaxation.
B) A coudé-tipped catheter is passed more easily in the older man with an enlarged prostate.
C) Sterile technique should always be used when inserting catheters.
D) The catheter should not be taped to the leg. It should be attached to a urinary drainage bag.
Page Ref: 344
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 5.B. Analyze bladder incontinence and retention as they relate to elimination. Differentiate care of patients with bladder incontinence and retention across the lifespan.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bladder incontinence and retention.

11) The nurse at a health fair is educating clients on risk factors associated with urinary incontinence. Which risk factor should the nurse include as a nonmodifiable risk factor for urinary incontinence?
A) Age
B) Obesity
C) Smoking
D) Diabetes
Answer: A
Explanation: A) Age is a nonmodifiable risk factor and is a primary risk factor for the development of urinary incontinence; older individuals experience more frequent incontinence than younger individuals.
B) Age is a nonmodifiable risk factor and is a primary risk factor for the development of urinary incontinence; older individuals experience more frequent incontinence than younger individuals. Obesity is a modifiable risk factor for urinary incontinence.
C) Smoking is a modifiable risk factor for urinary incontinence.
D) Diabetes is a modifiable risk factor for urinary incontinence.
Page Ref: 335
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 5.B. Analyze bladder incontinence and retention as they relate to elimination. Compare the risk factors and prevention of bladder incontinence and retention.

MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bladder incontinence and retention.

12) The nurse is caring for a client with urge incontinence. Which condition should the nurse recognize that contributes to the development of this type of incontinence?
A) Weakness of the urethra and surrounding tissue leading to decreased urethral resistance
B) Disruption to neuronal control of the sacral micturition centers due to tissue damage
C) An overactive detrusor muscle leading to increased pressure within the bladder
D) Outlet obstruction leading to the overfilling of the bladder and increased pressure
Answer: C
Explanation: A) Weakness of the urethra and surrounding tissue leading to decreased urethral resistance is a contributor to stress incontinence.
B) Disruption to neuronal control of the sacral micturition centers due to tissue damage is a contributor to reflex incontinence.
C) An overactive detrusor muscle leading to increased pressure within the bladder is a contributor to urge incontinence.
D) Outlet obstruction leading to the overfilling of the bladder and increased pressure is a contributor to overflow incontinence.
Page Ref: 335
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.B. Analyze bladder incontinence and retention as they relate to elimination. Identify the clinical manifestations of bladder incontinence and retention.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bladder incontinence and retention.

Exemplar 5.C Bowel Incontinence, Constipation, and Impaction

1) A client who ignores the urge to defecate states, "I don't like to have a bowel movement anywhere but at home." Which response by the nurse should the nurse make?
A) "This is a common practice, and it will strengthen the reflex later."
B) "You will get the urge later, so you should not worry about it."
C) "If you continue to ignore the urge to defecate, it can lead to problems."
D) "It is better to suppress the urge than to suffer embarrassment at work."
Answer: C
Explanation: A) Ignoring the urge will not strengthen the reflex later; it will weaken it.
B) When the urge to defecate is ignored, water continues to be reabsorbed, making the feces hard and difficult to expel.
C) When the normal defecation reflexes are inhibited, these conditioned reflexes tend to be progressively weakened. Ignoring the urge repeatedly will eventually cause the urge to be lost.
D) Embarrassment, while unwarranted, is preferable to losing the urge to defecate.
Page Ref: 347
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 5.C. Analyze bowel incontinence, constipation, and impaction as they relate to elimination. Describe the etiology of bowel incontinence, constipation, and impaction.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bowel incontinence, constipation, and impaction.

2) A client in the ambulatory care clinic reports frequent constipation. Which statement about the client's diet would be of greatest concern for the nurse?
A) "I like to eat a bran muffin and applesauce every morning for breakfast."
B) "I like to eat popcorn for an afternoon snack."
C) "I like to eat cheese, a banana, and a turkey sandwich for lunch."
D) "I like to eat baked chicken, whole grain rolls, and a small salad for dinner."
Answer: C
Explanation: A) Bran muffins and applesauce will prevent constipation.
B) Popcorn would prevent constipation.
C) Both cheese and bananas are constipating foods that should be limited.
D) Whole grains and salad would prevent constipation.
Page Ref: 349
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.C. Analyze bowel incontinence, constipation, and impaction as they relate to elimination. Compare the risk factors and prevention of bowel incontinence, constipation, and impaction.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bowel incontinence, constipation, and impaction.

3) An older adult client reports being constipated. Which response should the nurse make?
A) Encourage the client to increase fluid intake and activity.
B) Assess the client's intake of fiber and fluids.
C) Determine what the client means by constipation.
D) Obtain an order for a laxative and an enema from the physician.
Answer: C
Explanation: A) Increasing fluid intake and activity may be appropriate once the nurse has adequately assessed the client's concern of constipation.
B) Assessing the intake of fiber and fluids may be appropriate once the nurse has adequately assessed the client's concern of constipation.
C) Many older adults believe that a daily bowel movement is important for health, which leads to an increased incidence of perceived constipation in older adults. The nurse should first carefully evaluate the client's concern and question the person as to what is meant by constipation. Determining the client's normal frequency of bowel movements, consistency of stool, and effort in passing stool is important before deciding to act.
D) Laxatives and enemas may be appropriate once the nurse has adequately assessed the client's concern of constipation.
Page Ref: 352
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 5.C. Analyze bowel incontinence, constipation, and impaction as they relate to elimination. Differentiate care of patients with bowel incontinence, constipation, and impaction across the lifespan.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bowel incontinence, constipation, and impaction.

4) The nurse is planning care for a newly admitted, bedbound, older adult client. Which problem should the nurse use to guide the care of this client?

A) Fecal incontinence

B) Low self-esteem

C) Diarrhea

D) Constipation

Answer: D

Explanation: A) Lack of sphincter control, not bedrest, contributes to fecal incontinence.

B) Low self-esteem would affect a client who has undergone a bowel diversion.

C) Diarrhea would come from a GI upset triggered by diseases, medication, or diet.

D) Lack of activity, like being bedbound, is a major contributor to constipation. Lack of movement slows bowel movements.

Page Ref: 356

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 5.C. Analyze bowel incontinence, constipation, and impaction as they relate to elimination. Apply the nursing process in providing culturally competent care to an individual with bowel incontinence, constipation, or impaction.

MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bowel incontinence, constipation, and impaction.

5) The nurse instructs a client on dietary changes to reduce constipation. Which food selections by the client indicate that teaching has been effective? **Select all that apply.**
A) Rice
B) Carrot slices
C) Spinach salad
D) Bananas
E) Peas
Answer: B, C, E
Explanation: A) Rice is a constipating food.
B) Dietary fiber increases stool bulk. Carrots are an excellent source of dietary fiber.
C) Dietary fiber increases stool bulk. Spinach salad is an excellent source of dietary fiber.
D) Bananas are a constipating food.
E) Dietary fiber increases stool bulk. Peas are an excellent source of dietary fiber.
Page Ref: 349
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 5.C. Analyze bowel incontinence, constipation, and impaction as they relate to elimination. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with bowel incontinence, constipation, or impaction.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bowel incontinence, constipation, and impaction.

6) The nurse instructs a client with diarrhea about the medication loperamide. Which client statement indicates the need for further education?

A) "If my diarrhea does not get better within 2 days, I will need to call my healthcare provider for further advice."

B) "I will need to take the medication after each loose stool."

C) "I should continue to take this medication daily until my stools are firm and dry."

D) "If I start to have a fever, I need to contact my healthcare provider about continuing to take this medication."

Answer: C

Explanation: A) The client should call the healthcare provider if the diarrhea does not subside in 2 days.

B) The medication should be taken as prescribed.

C) Continuing to take the medication daily until the stools are firm and dry could result in constipation. If constipation occurs, the client will have another issue for resolution.

D) The client should contact the healthcare provider if a fever develops.

Page Ref: 354

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 5.C. Analyze bowel incontinence, constipation, and impaction as they relate to elimination. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with bowel incontinence, constipation, or impaction.

MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bowel incontinence, constipation, and impaction.

7) The nurse provides education and supportive assistance for the family of a preschool-age client diagnosed with encopresis. Which statement indicates parental understanding of appropriate care? **Select all that apply.**
A) "We will establish a limited schedule of activities that has many breaks to provide opportunities to use the toilet regularly."
B) "We will schedule an appointment with a play therapist to help our older child adjust to our new baby."
C) "We won't change our child's diet because we are afraid it will be stress provoking."
D) "We will work on regular elimination after morning and evening meals."
E) "We will continue to punish our child for having accidents as the behavior is learned and attention seeking."
Answer: A, B, D
Explanation: A) The underlying constipation that leads to encopresis may be caused by the stress of a full schedule of activities or other environmental changes (e.g., birth of a sibling).
B) Psychotherapy involving the child and family may be indicated in instances of dysfunctional parent—child relationships or in cases of suspected sexual abuse.
C) Dietary changes including incorporating high-fiber foods and limiting refined and highly processed foods and dairy products may be helpful.
D) It takes several months for the bowel to be retrained to respond to sphincter stimulation.
E) It is inappropriate to punish the child for having the accidents because they cannot be helped due to the underlying constipation.
Page Ref: 355
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 5.C. Analyze bowel incontinence, constipation, and impaction as they relate to elimination. Apply the nursing process in providing culturally competent care to an individual with bowel incontinence, constipation, or impaction.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bowel incontinence, constipation, and impaction.

8) The nurse is caring for a client with chronic constipation. Which findings in the client's health history could be the cause of the current constipation? **Select all that apply.**

A) Bedrest
B) High-fiber diet
C) Low-fiber foods
D) Chronic laxative use
E) Depression

Answer: A, C, D, E

Explanation: A) Factors that contribute to chronic constipation include lack of activity, such as bedrest.
B) A high-fiber diet is a treatment option for chronic constipation.
C) Factors that contribute to chronic constipation include a low fiber diet.
D) Factors that contribute to chronic constipation include chronic laxative use.
E) Factors that contribute to chronic constipation include depression.

Page Ref: 347

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 5.C. Analyze bowel incontinence, constipation, and impaction as they relate to elimination. Compare the risk factors and prevention of bowel incontinence, constipation, and impaction.

MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bowel incontinence, constipation, and impaction.

9) A client with constipation is prescribed a bulk-forming laxative. Which consideration should the nurse keep in mind when administering this medication to the client?
A) Offering sufficient water
B) Administering rectally
C) Using to treat acute constipation
D) Assessing for tardive dyskinesia
Answer: A
Explanation: A) It is imperative that bulk-forming laxatives be taken with sufficient water.
B) Bulk-forming laxatives are taken by mouth.
C) Bulk-forming laxatives are not typically for use in the treatment of acute constipation, as results from the medication are not immediate.
D) Bulk-forming laxatives do not cause tardive dyskinesia.
Page Ref: 350
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 5.C. Analyze bowel incontinence, constipation, and impaction as they relate to elimination. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with bowel incontinence, constipation, or impaction.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bowel incontinence, constipation, and impaction.

10) The nurse is reviewing discharge instructions with the mother of a toddler who was hospitalized for constipation. Which statement made by the toddler's mother indicates the need for further education?
A) "I should recognize that when my child walks stiffly on his tiptoes, this could indicate withholding."
B) "Rocking and crossing the legs could be a sign of withholding."
C) "I need to make sure my child eats a low-fiber diet."
D) "Soiling could be a sign of withholding because of involuntary overflow."
Answer: C
Explanation: A) Walking on tiptoes could indicate withholding of stool.
B) Rocking and crossing the legs could indicate withholding of stool.
C) This child requires a diet that is high in fiber.
D) Soiling could be an indication of withholding stool.
Page Ref: 353
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 5.7. Analyze bowel incontinence, constipation, and impaction as they relate to elimination. Differentiate care of patients with bowel incontinence, constipation, and impaction across the lifespan.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bowel incontinence, constipation, and impaction.

11) The nurse is preparing to teach a class on the prevention of constipation. Which food choice should the nurse include as an example of a high-fiber food?
A) Raw fruits
B) Cooked vegetables
C) White bread
D) Cooked fruits
Answer: A
Explanation: A) Foods high in fiber include raw fruits, bran products, and whole grain products.
B) Low-fiber foods would include cooked vegetables.
C) Low-fiber foods include white bread.
D) Low-fiber foods would include cooked fruits.
Page Ref: 349
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 5.C. Analyze bowel incontinence, constipation, and impaction as they relate to elimination. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with bowel incontinence, constipation, or impaction.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bowel incontinence, constipation, and impaction.

12) A client seeks medical attention for a "change" in bowel movements. Which clinical manifestation should the nurse expect if the client has a fecal impaction?
A) No passage of stool or fecal material of any kind
B) Passage of soft, formed stools
C) Passage of lumpy stools that are hard and dry
D) Passage of liquid, foul-smelling fecal material in the absence of formed stool
Answer: D
Explanation: A) Passing no stool or fecal material is indicative of an obstruction.
B) Soft, formed stools are generally considered normal.
C) Lumpy stools that are hard and dry are indicative of constipation.
D) Clients with a fecal impaction pass liquid, foul-smelling fecal material in the absence of formed stool; this is the liquid portion of the feces that seeps around the impacted mass.
Page Ref: 347
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.C. Analyze bowel incontinence, constipation, and impaction as they relate to elimination. Identify the clinical manifestations of bowel incontinence, constipation, and impaction.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bowel incontinence, constipation, and impaction.

13) A client with acute constipation is prescribed a diagnostic barium enema. For which health problem is this diagnostic test indicated?
A) Rectal muscle contractions
B) Completeness of bowel elimination
C) Efficiency with which the food moves through the gastrointestinal tract
D) Structure of the bowel or the presence of tumors or diverticula
Answer: D
Explanation: A) A defecography is used to assess rectal muscle contractions.
B) An anorectal manometry is used to assess the completeness of bowel elimination.
C) A colorectal transit study is used to determine how efficiently food moves through the gastrointestinal tract.
D) A barium enema is used to identify bowel structure, tumors, or diverticula.
Page Ref: 349
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.C. Analyze bowel incontinence, constipation, and impaction as they relate to elimination. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with bowel incontinence, constipation, or impaction.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with bowel incontinence, constipation, and impaction.

Exemplar 5.D Urinary Calculi

1) A client reports severe flank pain that radiates from the lower back to the lower abdomen causing spasms, nausea, vomiting, and oliguria. Which action should the nurse take?
A) Complete the physical assessment
B) Notify the health care provider
C) Instruct the client to increase fluids
D) Obtain a urine specimen for culture
Answer: B
Explanation: A) The physical assessment can be completed later.
B) Hydroureter is a complication that occurs when a renal calculus moves into the ureter and blocks and dilates the ureter. Symptoms include severe pain and spasms, nausea, vomiting, and diminished volume of urine. Hydroureter is a medical emergency that can lead to shock, infection, and subsequent impaired renal function; medical collaboration should be initiated immediately.
C) Increasing fluids will not be helpful.
D) The client has oliguria, and a urine specimen might not be possible.
Page Ref: 362
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.1 Demonstrate an understanding of the discipline of nursing's distinct perspective and where shared perspectives exist with other disciplines. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Identify the clinical manifestations of urinary calculi.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

2) The nurse is reviewing information provided during hand-off communication. Which client should the nurse identify as being at risk for developing urinary stones?
A) A 35-year-old woman with quadriplegia from an auto accident
B) A 65-year-old man with a recent history of myocardial infarction
C) A 50-year-old man with type 2 diabetes mellitus
D) A 25-year-old woman with several episodes of urinary infection
Answer: A
Explanation: A) The 35-year-old woman with quadriplegia from an auto accident experiences prolonged immobility, which will increase calcium loss from bones and therefore increase the chance of calcium stones precipitating in the urinary system.
B) A 65-year-old man with a recent history of myocardial infarction does not have a great risk.
C) A 50-year-old man with type 2 diabetes mellitus is not at risk.
D) A 25-year-old woman with several episodes of urinary infection is not at risk.
Page Ref: 360
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Compare the risk factors and prevention of urinary calculi.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

3) The nurse is preparing a presentation about renal conditions for a community fair. Which information should the nurse include regarding renal stones?

A) Older adult clients are particularly at risk for urolithiasis.
B) Men have a greater risk than women.
C) Women have a greater risk overall than men.
D) Frequency of stones is greater in the northern United States.

Answer: B

Explanation: A) Older adults are not at risk for urolithiasis.
B) Males are at greater risk for kidney stones than females.
C) Women have a lesser risk than men for renal stones.
D) In the United States, the incidence varies by region, with the highest frequency in the South.

Page Ref: 360

Cognitive Level: Applying

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Compare the risk factors and prevention of urinary calculi.

MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

4) A client is admitted to the emergency department and diagnosed with renal colic after experiencing symptoms for 1 week, including those associated with the body's sympathetic response to severe pain. Which problem should the nurse use to plan care for this client?
A) Risk for infection
B) Anxiety
C) Imbalanced nutrition
D) Lack of knowledge
Answer: C
Explanation: A) Risk for infection is not appropriate because the symptoms of urinary calculi do not lead to these diagnoses.
B) Anxiety is not appropriate because the symptoms of urinary calculi do not lead to these diagnoses.
C) The client with renal colic of lengthy duration is at risk for imbalanced nutrition from the resulting nausea.
D) Lack of knowledge is not appropriate because the symptoms of urinary calculi do not lead to these diagnoses.
Page Ref: 370
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Identify the clinical manifestations of urinary calculi.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

5) A client is diagnosed with calcium phosphate kidney stones. Which foods should the nurse teach the client to avoid?
A) Chicken, beef, and ham products
B) Organ meats, sardines, and seafood
C) Tomatoes, fruits, and potatoes
D) Spinach, nuts, wheat
Answer: D
Explanation: A) Chicken, beef, and ham are not high in calcium and do not need to be restricted for this client.
B) Organ meats, sardines, and seafood are not high in calcium and do not need to be restricted for this client.
C) Tomatoes, fruits, and potatoes are not high in calcium and do not need to be restricted for this client.
D) Calcium stones can be prevented by reducing sodium and animal protein intake, getting enough calcium from food, and avoiding foods high in oxalate (e.g., spinach, nuts, wheat bran).
Page Ref: 360
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with urinary calculi.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

6) A client with urinary calculi is admitted to the hospital. When planning care for this client, which goal is most appropriate?
A) The client will lose 25 pounds in 3 months.
B) The client will ambulate three times a day.
C) The client will request pain medication at the onset of pain.
D) The client will shower independently.
Answer: C
Explanation: A) Weight loss is not necessarily a goal with this disease process.
B) The client with urinary calculi is able to ambulate independently.
C) Intense pain is the hallmark of urinary calculi, or kidney stones, that are passing through the urinary system. The client should request pain medication at the onset of pain in order to provide faster relief.
D) The client with urinary calculi is able to shower independently.
Page Ref: 370
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Apply the nursing process in providing culturally competent care to an individual with urinary calculi.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

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7) The nurse is providing care to a client whose medication therapy for the treatment of renal calculi has failed. Based on this data, which treatment option does the nurse anticipate for this client?
A) Lithotripsy
B) Surgical removal
C) Dietary control
D) Initiation of IV fluids
Answer: A
Explanation: A) When medication fails to dissolve stones, the preferred method of treatment is lithotripsy, which is using sound waves to crush the stones so they can be passed out of the urinary system.
B) Depending on the location of the stones, surgery may be the next step in the treatment process.
C) Diet is used to prevent further stone formation.
D) Fluids are used to prevent further stone formation.
Page Ref: 363
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.1 Demonstrate an understanding of the discipline of nursing's distinct perspective and where shared perspectives exist with other disciplines. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with urinary calculi.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

8) The nurse is preparing to discharge a client who underwent lithotripsy for the treatment of a struvite kidney stone. Which information should the nurse teach the client to prevent further complications of urinary calculi after discharge?
A) "You will need to increase your oral fluid intake to 1 L/day."
B) "It will be important that you not drive while taking pain medications."
C) "It will be important to maintain a diet high in purines."
D) "You will need to monitor for the signs and symptoms of a urinary tract infection (UTI)."
Answer: D
Explanation: A) Fluid intake per day should be 2.5-3.0 L.
B) By discharge, the stones should have passed and there would be no need for pain medication.
C) Foods high in purines, such as organ meats, are to be avoided.
D) The client with struvite stones may develop a UTI when formed stones obstruct urinary flow. These symptoms should be reported as early as possible to the primary care provider.
Page Ref: 360
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Apply the nursing process in providing culturally competent care to an individual with urinary calculi.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

9) A client is complaining of dull flank pain. List the order of the steps the nurse should take in conducting the physical assessment for this client.
1. Instruct the client.
2. Assess the general appearance.
3. Position the client.
4. Inspect the abdomen for color, contour, symmetry, and distention.
Answer: 1, 3, 2, 4
Explanation: A quick survey of the client enables the nurse to identify any immediate problem as well as the client's ability to participate in the assessment. Begin the examination with the client in a supine position with the abdomen exposed from the nipple line to the pubis. Assess general appearance and inspect the client's skin for color, hydration status, scales, masses, indentations, or scars.
Page Ref: 365
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Apply the nursing process in providing culturally competent care to an individual with urinary calculi.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

10) The nurse is providing care for a client with renal calculi. Which expected outcomes will the nurse include in this client's plan of care? **Select all that apply.**
A) The client rates pain at a 3 on a scale of 0-10 and states that a 3 is acceptable.
B) The client is able to comfortably perform activities of daily living (ADLs).
C) The client demonstrates a fluid intake of 800-1000mL/day.
D) The client remains free of signs and symptoms of infection.
E) The client chooses the appropriate diet to prevent the recurrence of renal calculi.
Answer: A, B, D, E
Explanation: A) Client outcomes should include the client's rating pain at 3 or less on a 0-10 scale.
B) Client outcomes should include being comfortable enough to perform own ADLs.
C) The client's fluid intake should be 2-3 liters a day.
D) The client should be free of signs and symptoms of infection.
E) The client should be instructed on the appropriate diet to prevent the recurrence of renal calculi.
Page Ref: 370
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Apply the nursing process in providing culturally competent care to an individual with urinary calculi.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

11) A client with gout has also been diagnosed with uric acid renal calculi. When planning meals for this client, which diet will the nurse anticipate?
A) Low-purine diet
B) Low-sodium diet
C) A diet high in calcium
D) A diet low in calcium
Answer: A
Explanation: A) A low-purine diet is appropriate in the management of a client with uric acid renal calculi.
B) A low-sodium diet is useful in the management of a client with cystine renal calculi.
C) A diet limiting foods high in calcium is useful when managing a client with calcium phosphate renal calculi.
D) A diet limiting foods high in calcium is useful when managing a client with calcium phosphate renal calculi.
Page Ref: 360
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with urinary calculi.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

12) A client with inflammatory bowel disease has also been diagnosed with calcium phosphate renal calculi. When planning care for this client, which type of medication does the nurse anticipate based on the data?
A) Antibiotic
B) Allopurinol
C) Nonsteroidal anti-inflammatory drug (NSAID)
D) Thiazide diuretic
Answer: D
Explanation: A) Antibiotics are used to help prevent struvite stones.
B) Allopurinol is often prescribed to prevent stones that tend to form in acidic urine (uric acid).
C) Nonsteroidal anti-inflammatory drugs (NSAIDs) are used to treat pain and discomfort and may reduce the amount of narcotic analgesia required for acute renal colic.
D) A thiazide diuretic is used to prevent the formation of calcium stones.
Page Ref: 360
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 1.1 Demonstrate an understanding of the discipline of nursing's distinct perspective and where shared perspectives exist with other disciplines. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with urinary calculi.

MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

13) The nurse is assessing an older adult client whose primary symptoms include fatigue, pruritus, and pain in the right flank area. Which technique should the nurse avoid during the assessment?
A) Palpation over the costovertebral angles and flanks
B) Blunt percussion over the costovertebral angles and flanks
C) Palpation of the lower pole of both kidneys
D) Capturing of both kidneys
Answer: B
Explanation: A) Palpation of the costovertebral angles and flanks can be used to reveal any pain or tenderness.
B) Blunt percussion in a frail older individual is contraindicated.
C) Palpating the lower pole of both kidneys would be appropriate.
D) Capturing both kidneys would be appropriate.
Page Ref: 364
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Differentiate care of patients with renal calculi across the lifespan.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

14) The urinalysis of a client with frequency, urgency, and dysuria reveals nucleation. Which statement should the nurse understand about the composition of the client's urine?
A) It has a high concentration of citrate and glycoproteins.
B) It has a pH of 7.0.
C) It contains trace amounts of blood.
D) It has a high concentration of insoluble salt.
Answer: D
Explanation: A) Citrate and glycoproteins are protective substances in the urine that prevent crystals from forming and would be low in urine containing crystals.
B) A pH of 7.0 is neutral, and urine crystals tends to be either acid or alkaline.
C) While trace amounts of blood may be in the urine, blood is not a finding consistent with crystal formation.
D) High insoluble salt concentration in the urine–known as supersaturation–leads to formation of crystals in the urine.
Page Ref: 359
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Describe the pathophysiology of urinary calculi.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

15) The nurse is asked to explain the difference between calcium phosphate stones from uric acid and cystine stones. Which statement should the nurse make?
A) Calcium phosphate stones are associated with alkaline urine, while uric acid and cystine stones are associated with acid urine.
B) Calcium phosphate stones are associated with acid urine, while uric acid and cystine stones are associated with alkaline urine.
C) Calcium phosphate stones are associated with alkaline urine, while uric acid and cystine stones are associated with neutral urine.
D) Calcium phosphate stones are associated with neutral urine, while uric acid and cystine stones are associated with acid urine.
Answer: A
Explanation: A) Calcium phosphate stones are associated with alkaline urine, while uric acid and cystine stones are associated with acid urine.
B) Calcium phosphate stones are associated with alkaline urine, while uric acid and cystine stones are associated with acid urine.
C) None of the types of stones discussed are associated with urine that has a neutral pH.
D) Calcium phosphate stones are associated with alkaline urine, while uric acid and cystine stones are associated with acid urine.
Page Ref: 360
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Describe the pathophysiology of urinary calculi.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

16) The nurse is caring for clients with renal calculi. Of these clients, which one should the nurse identify as having the *highest* likelihood of requiring surgery to remove the calculi?
A) A 7-year-old with calcium phosphate stones of the bladder
B) A 78-year-old client with struvite stones of the kidney
C) A 31-year-old expectant mother with calcium oxalate stones of the kidney
D) A 46-year-old with uric acid stones of the bladder
Answer: B
Explanation: A) A 7-year-old client would not need surgery but may need other nonsurgical interventions.
B) Older individuals are less likely to pass a stone spontaneously and are more likely to require surgical intervention for stones. Additionally, struvite stones are more often treated with surgical intervention than other types of stones.
C) Surgery is contraindicated in pregnant clients.
D) The client with uric acid stones may require interventions but not surgery.
Page Ref: 365
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 5.D. Analyze urinary calculi as they relate to elimination. Differentiate care of patients with urinary calculi across the lifespan.
MNL LO: Demonstrate understanding of the concept of elimination in the care of a patient with urinary calculi.

***Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e* (Pearson)**

Module 6 Fluids and Electrolytes

The Concept of Fluids and Electrolytes

1) A client with a fluid volume deficit is experiencing tachycardia, decreased urine output, and pale, cool skin. Which cause should the nurse anticipate as the reason for the client's symptoms?
A) Natural compensatory mechanisms
B) Cardiac failure
C) Pharmacological effects of a diuretic
D) Rapidly infused intravenous fluids
Answer: A
Explanation: A) Compensatory mechanisms to conserve water and sodium and maintain circulation account for many of the manifestations of FVD.
B) The manifestations reported are not indicative of cardiac failure in this client.
C) A diuretic would cause further fluid loss and is contraindicated.
D) Rapidly infused intravenous fluids would not cause a decrease in urine output.
Page Ref: 401
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.2. Differentiate alterations in fluids and electrolytes.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

2) A client's serum calcium level is increasing a few days after surgery. Which intervention should the nurse implement to decrease the client's possibility of developing hypercalcemia?
A) Measure the client's vital signs every 8 hours.
B) Assist the client in ambulating around the room at least three times daily.
C) Irrigate the client's indwelling urinary catheter daily.
D) Help the client turn, cough, and deep breathe every 2 hours.
Answer: B
Explanation: A) Measuring vital signs will not prevent the development of hypercalcemia.
B) Hypercalcemia can occur from immobility. Ambulation helps prevent leaching of calcium from the bones into the serum.
C) Irrigating the indwelling urinary catheter will not prevent the development of hypercalcemia.
D) Deep breathing and coughing will not prevent the development of hypercalcemia.
Page Ref: 384
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 6.4. Explain the promotion of maintaining fluid and electrolyte balance.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

3) A client has a phosphate level of 2.0 mg/dL. Which action should the nurse take?
A) Enforce contact precautions.
B) Encourage consumption of a high-calorie carbohydrate diet.
C) Strain all urine.
D) Encourage consumption of milk and yogurt.
Answer: D
Explanation: A) There is no need to place this client on contact precautions.
B) There is no need to increase the client's carbohydrate calorie intake.
C) There is no need to strain all urine.
D) A phosphorus level of 2.0 is low, so the client will need additional dietary phosphorus. Providing phosphorus-rich foods such as milk and yogurt is a good way to provide that additional phosphorus.
Page Ref: 384
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 6.4. Explain the promotion of maintaining fluid and electrolyte balance.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

4) A mother reports that a 3-month-old infant has been vomiting and experiencing diarrhea for several days. Which response should the nurse make?
A) "You should bring the infant in to be seen by the doctor."
B) "Give your baby at least 2 ounces of juice every 2 hours."
C) "Give your baby 50 mL of glucose water every hour."
D) "Measure your baby's urine output for 24 hours and call back tomorrow."
Answer: A
Explanation: A) Parents and caregivers need to be taught the seriousness of vomiting or diarrhea in infants due to rapid fluid loss that can occur in this age group. They should also be taught the importance of bringing an infant in this situation to healthcare providers for evaluation.
B) Encouraging fluids for an infant who is actively vomiting will not improve fluid balance status, and juice is not the best choice of fluid.
C) Encouraging fluids for an infant who is actively vomiting will not improve fluid balance status, and glucose water is not the best choice of fluid.
D) Simply monitoring the loss over the next 24 hours would increase the potential for the infant to become dehydrated.
Page Ref: 394
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 6.8. Differentiate considerations related to the care of patients with alterations in fluid and electrolyte balance throughout the lifespan.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

5) A client taking furosemide (Lasix) has a serum potassium, of 3.4 mEq/L. Which food should the nurse encourage the client to consume?
A) Baked fish
B) Iced tea
C) Banana
D) White bread
Answer: C
Explanation: A) Baked fish is not a high-potassium food.
B) Iced tea is not a high-potassium food.
C) A potassium level of 3.4 mEq/L is low, so the client should be encouraged to consume potassium-rich foods. Of the foods listed, banana is the highest in potassium.
D) White bread is not a high-potassium food.
Page Ref: 384
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 6.4. Explain the promotion of maintaining fluid and electrolyte balance.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

6) The nurse is reviewing laboratory data for a group of clients. Which total serum calcium levels would the nurse consider normal in an adult client?
A) 9.88 mg/dL
B) 2.21 mg/dL
C) 4.87 mg/dL
D) 7.03 mg/dL
Answer: A
Explanation: A) Normal total serum calcium levels, which represent both bound and unbound calcium, range from 9 to 11 mg/dL.
B) This is a severely low calcium level.
C) This is a severely low calcium level.
D) This is a low calcium level.
Page Ref: 384
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.5. Differentiate among common assessment procedures and tests used to examine fluid and electrolyte balance.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

7) A client who weighs 154 lbs. is receiving intravenous fluid replacement therapy. Which urinary output would indicate that efforts to rehydrate this client have been successful?
A) 40 mL per hour
B) 20 mL per hour
C) 25 mL per hour
D) 30 mL per hour
Answer: A
Explanation: A) Normal urine output for an adult client is at least 0.5 mL/kg per hour. This client weighs 70 kg, so adequate urine output would be at least 35 mL per hour. Thus, the only option that indicates adequate urine output is 40 mL per hour.
B) Normal urine output for an adult client is at least 0.5 mL/kg per hour. This client weighs 70 kg, so adequate urine output would be at least 35 mL per hour. A urine output of 20 mL/hour indicates that rehydration efforts have not been successful.
C) Normal urine output for an adult client is at least 0.5 mL/kg per hour. This client weighs 70 kg, so adequate urine output would be at least 35 mL per hour. A urine output of 25 mL/hour indicates that rehydration efforts have not been successful.
D) Normal urine output for an adult client is at least 0.5 mL/kg per hour. This client weighs 70 kg, so adequate urine output would be at least 35 mL per hour. A urine output of 30 mL/hour indicates that rehydration efforts have not been successful.
Page Ref: 390
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 6.5. Differentiate among common assessment procedures and tests used to examine fluid and electrolyte balance.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

WwW.TeSt.Ws

8) An older adult client has intermittent confusion after a fall. Which condition is the client most at risk for developing?
A) Kidney damage
B) Dehydration
C) Stroke
D) Bleeding
Answer: B
Explanation: A) The risk for kidney damage is not specifically related to aging or fluid and electrolyte issues.
B) As an adult ages, the thirst mechanism declines. Also, an altered level of consciousness can increase the risk of dehydration and high serum osmolality.
C) The risk for stroke is not specifically related to aging or fluid and electrolyte issues.
D) The risk for bleeding is not specifically related to aging or fluid and electrolyte issues.
Page Ref: 396
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 6.8. Differentiate considerations related to the care of clients with alterations in fluid and electrolyte balance throughout the lifespan.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

9) An older adult client receiving intravenous fluids at 150 mL/hr has crackles, shortness of breath, and jugular vein distention. For which complication of IV fluid therapy should the nurse plan care?
A) Speed shock
B) Fluid volume excess
C) Pulmonary embolism
D) An allergic reaction
Answer: B
Explanation: A) The manifestations do not support speed shock.
B) Fluid volume excess may occur if clients, especially the very young or old, receive IV fluid rapidly.
C) The manifestations do not support a pulmonary embolism.
D) The manifestations do not support an allergic reaction.
Page Ref: 396
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 6.8. Differentiate considerations related to the care of patients with alterations in fluid and electrolyte balance throughout the lifespan.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

10) A client is exhibiting clinical manifestations of a severe fluid and electrolyte imbalance. Which prescriptions should the nurse anticipate from the healthcare provider? **Select all that apply.**
A) Initiate intravenous therapy
B) Initiate hypodermoclysis
C) Administer antibiotics
D) Administer diuretics
E) Administer red blood cells
Answer: A, B, D
Explanation: A) If the client is experiencing a fluid volume deficit, intravenous fluids may be ordered if replacement oral fluids cannot be taken in sufficient quantity.
B) Hypodermoclysis, or subcutaneous administration of fluid, may also be employed as a delivery method, especially among older adults.
C) Antibiotics are not used for fluid and electrolyte imbalance.
D) If the client is experiencing a fluid volume excess, diuretics may be ordered.
E) Blood transfusion is implemented for blood loss, not for a fluid and electrolyte imbalance.
Page Ref: 393
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 6.7. Summarize collaborative therapies used by interdisciplinary teams for patients with alterations in fluid and electrolyte balance.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

11) The nurse is preparing to administer 20 mEq of potassium chloride to a client who has been vomiting. Which information about the purpose of this medication should the nurse explain to the client?
A) It is vital in regulating muscle contraction and relaxation.
B) It is needed to maintain skeletal, cardiac, and neuromuscular activity.
C) It controls and regulates water balance in the body.
D) It is used to synthesize protein and DNA within the body's cells.
Answer: B
Explanation: A) Calcium is vital in regulating muscle contraction and relaxation.
B) Potassium is the major cation in intracellular fluids, with only a small amount found in plasma and interstitial fluid. Potassium is a vital electrolyte for skeletal, cardiac, and smooth muscle activity.
C) Sodium controls and regulates water balance in the body.
D) Magnesium is used in the cells to synthesize protein and DNA.
Page Ref: 383
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 6.1. Analyze the physiology of fluids and electrolytes in the body.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

12) The nurse is concerned that a client diagnosed with a fluid imbalance is at risk for an alteration in perfusion. Which assessment data should indicate to the nurse that the client has adequate perfusion? **Select all that apply.**

A) Skin turgor 20 seconds
B) Peripheral pulses present and full
C) Capillary refill of nail beds 3 seconds
D) Oriented to person, place, and time
E) Bowel sounds sluggish in all four quadrants

Answer: B, C, D

Explanation: A) Skin turgor would be used to determine whether the fluid imbalance is affecting the client's elimination status. Skin turgor that takes 20 seconds to return to normal indicates that the fluid imbalance is affecting the client's elimination status.
B) Full and present peripheral pulses indicates the client's perfusion status is being maintained.
C) Capillary refill of 3 seconds or less indicates that the client's perfusion status is being maintained.
D) Orientation to person, place, and time indicates that the client's perfusion status is being maintained.
E) Sluggish bowel sounds indicates that the fluid imbalance is affecting the client's elimination status.

Page Ref: 390-391
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.3. Outline the relationship between fluids and electrolytes and other concepts.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

WwW.TeSt.Ws

13) An adult client's serum sodium level is 150 mg/dL. Which interventions should the nurse plan for this client? **Select all that apply.**

A) Monitor heart rate and rhythm
B) Elevate the head of the bed
C) Instruct on a low-sodium diet
D) Administer diuretics as prescribed
E) Administer potassium supplement as prescribed

Answer: C, D

Explanation: A) Monitoring of heart rate and rhythm would be more appropriate if the client had a potassium imbalance.

B) Elevating the head of the bed would be appropriate if the client were demonstrating signs of fluid volume overload. The client's fluid volume status is not known at this time and raising the head of the bed would not be a routine intervention for a client with an elevated sodium level.

C) For an elevated sodium level, intake of this electrolyte will need to be restricted by adherence to a low-sodium diet.

D) Diuretics may also be prescribed, as certain diuretics block sodium absorption. Diuretics will also remove any excess fluid being held in the body because of the extra sodium.

E) A potassium imbalance is not associated with a sodium imbalance, so more information would be needed before a potassium supplement was prescribed.

Page Ref: 383
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 6.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in fluid and electrolyte balance.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

14) During an assessment, the nurse becomes concerned that an older adult client is at risk for dehydration. Which assessment finding would cause the nurse to come to this conclusion?
A) The client has poor skin turgor.
B) The client reports ingesting two glasses of water each day.
C) The client's blood pressure is 140/98 mmHg.
D) The client's body mass index is 20.5.
Answer: B
Explanation: A) Skin turgor is a poor indicator of fluid balance in older adult clients, as the skin's elasticity naturally decreases with age.
B) Poor intake of water (in this case, only 2 glasses per day) could indicate a loss of the thirst response, which is a normal age-related change that increases the risk for dehydration.
C) The client's blood pressure is elevated, but this could indicate either fluid volume overload or sodium sensitivity.
D) The client's body mass index is within normal limits and thus would not contribute to dehydration. Note, however, that a body mass index associated with overweight or obesity could be associated with dehydration, as fat cells contain little or no water.
Page Ref: 390-391
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 6.8. Differentiate considerations related to the care of patients with alterations in fluid and electrolyte balance throughout the lifespan.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

15) The nurse is reviewing laboratory values for a female client suspected of having a fluid imbalance. Which laboratory value should indicate to the nurse that the client is experiencing dehydration?
A) Serum osmolality 230 mOsm/kg
B) Hematocrit 30%
C) Hematocrit 53%
D) Serum potassium 3.8 mEq/L
Answer: C
Explanation: A) Serum osmolality is a measure of the solute concentration of the blood and is used to evaluate fluid balance. Normal values are 280-300 mOsm/kg. An increase in serum osmolality indicates a fluid volume deficit, whereas a decrease reflects fluid volume excess.
B) The hematocrit measures the volume of whole blood that is composed of RBCs. Because the hematocrit is a measure of the volume of cells in relation to plasma, it is affected by changes in plasma volume. A client's hematocrit increases with dehydration and decreases with overhydration. A normal hematocrit value for a female is 37% to 47%.
C) The hematocrit measures the volume of whole blood that is composed of RBCs. Because the hematocrit is a measure of the volume of cells in relation to plasma, it is affected by changes in plasma volume. A client's hematocrit increases with dehydration and decreases with overhydration. A normal hematocrit value for a female is 37% to 47%.
D) Serum potassium is not an electrolyte used to determine alterations in fluid balance. Serum sodium values would be more appropriate for that purpose.
Page Ref: 386
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.5. Differentiate among common assessment procedures and tests used to examine fluid and electrolyte balance.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

16) A client weighing 176 lbs. being treated for dehydration had a 24-hour intake of 2000 mL and urine output of 1200 mL. Which conclusion should the nurse make?
A) Treatment needs to include a diuretic.
B) Treatment has not been effective.
C) Treatment is effective and should continue.
D) Treatment has been effective and should end.
Answer: C
Explanation: A) A diuretic is not needed because the client is being treated for dehydration.
B) Treatment has been effective; however, it should continue until the intake and output are more balanced.
C) Urinary output is normally equivalent to the amount of fluids ingested; the usual range is 1500-2000 mL in 24 hours, or 40-80 mL in 1 hour (0.5 mL/kg per hour). Clients whose intake substantially exceeds output are at risk for fluid volume excess; however, this client is dehydrated, so the extra fluid intake is being used to improve body fluid balance. The client's output is 50 mL/hr, which is within the normal range.
D) Ending treatment now could further jeopardize this client's fluid balance.
Page Ref: 390
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 6.2. Differentiate alterations in fluids and electrolytes.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

17) A client seeks medical attention for a headache and nausea that developed after working in a factory without air conditioning during a high temperature day. The client reports drinking water several times throughout the day because of heavy sweating. Based on this data, which instruction is most appropriate for the nurse to give the client?
A) "Eat something sweet when drinking water."
B) "Eat something salty when drinking water."
C) "Double the amount of water you are drinking."
D) "Drink juices and carbonated sodas instead of water."
Answer: B
Explanation: A) Eating something sweet will not help replace sodium.
B) Both salt and water are lost through sweating. When only water is replaced, the individual is at risk for salt depletion. Symptoms include fatigue, weakness, headache, and gastrointestinal symptoms such as loss of appetite and nausea. Thus, the client should be instructed to eat something salty when drinking water to help replace the lost sodium.
C) Doubling the amount of water being ingested could lead to hyponatremia and further manifestations.
D) Consuming juices and carbonated sodas will not help replace the sodium.
Page Ref: 389
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 6.4. Explain the promotion of maintaining fluid and electrolyte balance.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

18) The nurse is reviewing the different electrolytes. Which electrolyte would be classified as a cation?
A) Chloride
B) Bicarbonate
C) Phosphate
D) Potassium
Answer: D
Explanation: A) Negatively charged electrolytes are called anions and include chloride.
B) Negatively charged electrolytes are called anions and include bicarbonate.
C) Negatively charged electrolytes are called anions and include phosphate.
D) Positively charged electrolytes are called cations and include potassium.
Page Ref: 378
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.1. Analyze the physiology of fluids and electrolytes in the body.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

19) The nurse is reviewing the pathophysiology of dehydration. Which statement will the nurse identify for a hypertonic state?
A) A dehydrated client would be considered to be in a hypotonic state because the client would have a lower concentration of solutes in the body in relation to water.
B) A dehydrated client would be considered to be in a hypertonic state because the client would have a lower concentration of solutes in the body in relation to water.
C) A dehydrated client would be considered to be in a hypotonic state because the client would have a higher concentration of solutes in the body in relation to water.
D) A dehydrated client would be considered to be in a hypertonic state because the client would have a higher concentration of solutes in the body in relation to water.
Answer: D
Explanation: A) Dehydration causes a hypertonic state.
B) Dehydration causes a hypertonic state; however, there is higher concentration of solutes in relation to water.
C) Dehydration causes a hypertonic state.
D) Dehydrated clients are hypertonic because there is a reduced percentage of water in their bodies and thus a higher concentration of solutes to water.
Page Ref: 379
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.1. Analyze the physiology of fluids and electrolytes in the body.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

20) The nurse is analyzing laboratory values for a client. Which laboratory value indicates hypokalemia?
A) Serum potassium of 3.25 mEq/L
B) Serum potassium of 5.45 mEq/L
C) Serum sodium of 125 mEq/L
D) Serum sodium of 155 mEq/L
Answer: A
Explanation: A) Hypokalemia is a deficit in potassium. Normal serum potassium levels range from 3.5 to 5.3 mEq/L, so of the choices listed, only a serum potassium of 3.25 mEq/L would be considered indicative of hypokalemia.
B) A potassium level of 5.45 mEq/L would be categorized as hyperkalemia.
C) A serum sodium level is not used to determine hypokalemia.
D) A serum sodium level is not used to determine hypokalemia.
Page Ref: 392
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.5. Differentiate among common assessment procedures and tests used to examine fluid and electrolyte balance.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

21) The nurse is reviewing the movements of fluids inside the body. Which process should the nurse identify where the fluid and solutes move together across a membrane from an area of higher pressure to one of lower pressure?
A) Osmosis
B) Filtration
C) Active transport
D) Diffusion
Answer: B
Explanation: A) Osmosis is the movement of water across cell membranes, from the less concentrated solution to the more concentrated solution.
B) Filtration is a process whereby fluid and solutes move together across a membrane from one compartment to another. The movement is from an area of higher pressure to one of lower pressure.
C) Active transport is the process by which substances move across cell membranes from a less concentrated solution to a more concentrated one.
D) Diffusion is the continual intermingling of molecules in liquids, gases, or solids brought about by the random movement of the molecules.
Page Ref: 379
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.1. Analyze the physiology of fluids and electrolytes in the body.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

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Exemplar 6.A Fluid and Electrolyte Imbalance

1) An older adult client experiencing fever, nausea, and vomiting for the past 2 days has a decreased urine specific gravity. For which condition should the nurse plan care for this client?
A) Congestive heart failure
B) Dehydration
C) Fluid overload
D) Normal changes of aging
Answer: B
Explanation: A) Congestive heart failure would present with respiratory difficulty and peripheral edema.
B) Older adult clients are less able to concentrate their urine, and they have a blunted perception of thirst. Both of these characteristics make them susceptible to dehydration. The client's symptoms of nausea and vomiting suggest decreased intake and increased output through vomiting, placing this client at even higher risk for dehydration.
C) Fluid overload would present with respiratory difficulty and peripheral edema.
D) Fever, nausea, and vomiting are not considered normal.
Page Ref: 399
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Differentiate considerations for care of patients with fluid volume deficit and dehydration across the lifespan.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

2) The nurse receives data received during hand-off communication. Which client should the nurse plan to assess first based on an increased risk for dehydration?
A) A 4-year-old child with a broken leg
B) A 15-month-old child with tachypnea
C) A 16-year-old child with migraine headaches
D) A 10-year-old child with cellulitis of the left leg
Answer: B
Explanation: A) The pediatric client with a fracture is at lower risk for dehydration.
B) The pediatric client with the greatest risk for dehydration is the client who is under 2 years of age and experiencing tachypnea, which increases insensible fluid loss.
C) Migraine headaches do not increase the risk for dehydration.
D) Cellulitis does not increase the risk for dehydration.
Page Ref: 402
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Differentiate considerations for care of patients with fluid volume deficit and dehydration across the lifespan.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

3) The nurse is teaching a group of children and their parents about the prevention of heat-related illness during exercise. Which statement by a parent indicates an appropriate understanding of the preventive techniques taught during the session?
A) "It is important for my child to wear dark clothing while exercising in the heat."
B) "Water is the drink of choice to replenish fluids that are lost during exercise."
C) "My child only needs to hydrate at the end of an exercise session."
D) "I will have my child stop every 15 to 20 minutes during physical activity to drink fluids."
Answer: D
Explanation: A) Wearing dark colors can increase sweating.
B) A combination of water and sports drinks is best to replace fluids lost during exercise.
C) Hydration should occur before and during the activity, not just at the end.
D) During activity, stopping for fluids every 15-20 minutes is recommended.
Page Ref: 399
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Compare the risk factors for and prevention of fluid volume deficit and dehydration.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

4) A client with dehydration has a low serum sodium level. For which problem should the nurse plan care for this client?
A) Isotonic dehydration
B) Hydrostatic pressure
C) Hypotonic dehydration
D) Osmotic pressure
Answer: C
Explanation: A) Isotonic dehydration occurs when fluid loss is not balanced by intake, and the losses of water and sodium are in proportion.
B) Hydrostatic pressure occurs when extracellular fluid volume excess occurs; the increased fluid volume in the vascular compartment congests the veins.
C) Hypotonic dehydration occurs when fluid loss is characterized by a proportionately greater loss of sodium than water, causing serum sodium to fall below normal levels.
D) Osmotic pressure pulls fluid into the capillaries, usually in response to the presence of albumin and other plasma proteins made by the liver.
Page Ref: 398
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Diagnosis
Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Describe the pathophysiology of fluid volume deficit and dehydration.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

5) The nurse is asked why a client receiving intravenous fluids after cardiac surgery is at risk for fluid volume excess. Which response should the nurse make?
A) "Fluid volume excess commonly occurs due to new onset liver failure caused by the surgery."
B) "Fluid volume excess is frequently caused by the administration of intravenous fluids."
C) "Fluid volume excess is common due to increased levels of antidiuretic hormone in response to the stress of surgery."
D) "Fluid volume excess is frequently caused by inactivity."
Answer: C
Explanation: A) Liver failure is not caused by cardiac surgery.
B) A fluid volume excess should not occur with the proper administration of intravenous fluids.
C) Antidiuretic hormone (ADH) and aldosterone levels are commonly increased following the stress response before, during, and immediately after surgery. This increase leads to sodium and water retention. Adding more fluids intravenously can cause a fluid volume excess and place stress on the heart and circulatory system.
D) Fluid volume excess is not a result of inactivity.
Page Ref: 405
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Describe the pathophysiology of fluid volume excess.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

6) The nurse notes that a client with fluid volume excess has severe, generalized edema. Which term will the nurse use to document this finding?
A) Ascites
B) Anasarca
C) Hypervolemia
D) Orthopnea
Answer: B
Explanation: A) Ascites refers to excess fluid in the peritoneal cavity.
B) Anasarca refers to severe, generalized edema, which may occur due to fluid volume excess.
C) Hypervolemia is an excess of intravascular fluid.
D) Orthopnea is difficulty breathing when supine.
Page Ref: 406
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Identify the clinical manifestations of fluid volume excess.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

7) The nurse is caring for a client with heart failure who is diagnosed with acute hypokalemia. Which drug on the client's medication administration record may have contributed to the client's current hypokalemic state?

A) Demerol
B) Cortisol
C) Hydrochlorothiazide
D) Skelaxin
Answer: B
Explanation: A) Narcotics would not cause acute hypokalemia.
B) Excess potassium loss through the kidneys is often caused by such medications as corticosteroids. Cortisol is a type of corticosteroid and can cause hypokalemia.
C) Hydrochlorothiazide would not cause acute hypokalemia.
D) Skelaxin is a muscle relaxant that does not cause acute hypokalemia.
Page Ref: 406
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Describe the etiology of fluid volume excess.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

8) The spouse of a client with a potassium level of 5.9 mEq/L asks why insulin is being used as treatment. Which response should the nurse make?
A) "The insulin will cause extra potassium to move into his cells, which will lower the potassium level in the blood."
B) "Insulin is safer than other medications that can lower potassium levels."
C) "The insulin lowers his blood sugar levels and causes the extra potassium to be excreted."
D) "The insulin will help his kidneys excrete the extra potassium."
Answer: A
Explanation: A) Serum potassium levels may be temporarily lowered by administering glucose and insulin, which cause potassium to leave the extracellular fluid and enter cells.
B) Giving insulin to decrease serum potassium levels is not considered a safer method than other medications that can be used.
C) Serum potassium is lowered by entering the cells; this is not controlled by serum glucose.
D) Insulin does not promote renal excretion of potassium.
Page Ref: 413
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 1.1 Demonstrate an understanding of the discipline of nursing's distinct perspective and where shared perspectives exist with other disciplines. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with fluid volume excess.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

9) A client in the emergency department is being admitted with a diagnosis of fluid volume deficit. When preparing to assess this client, on which body system should the nurse focus to determine the cause of the imbalance?

A) Cardiovascular
B) Genitourinary
C) Gastrointestinal
D) Musculoskeletal

Answer: C

Explanation: A) The client may demonstrate cardiovascular system changes because of the fluid volume deficit; however, this body system does not cause the deficit.

B) The client may demonstrate genitourinary system changes because of the fluid volume deficit; however, this body system does not cause the deficit.

C) The most common cause of fluid volume deficit is excessive loss of gastrointestinal fluids, which can result from vomiting, diarrhea, suctioning, intestinal fistulas, or intestinal drainage. Other causes of fluid losses include chronic abuse of laxatives and/or enemas.

D) The client may demonstrate musculoskeletal system changes because of the fluid volume deficit; however, this body system does not cause the deficit.

Page Ref: 399

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Describe the etiology of fluid volume deficit and dehydration.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

10) The school nurse is preparing a class session for high school students on ways to maintain fluid balance during the summer months. Which interventions should the nurse recommend to decrease the risk of fluid imbalance? **Select all that apply.**
A) Drink diet soda.
B) Drink more fluids during hot weather.
C) Drink flat, caffeine-free cola or ginger ale if vomiting.
D) Reduce the intake of coffee and tea.
E) Exercise between the hours of 10 a.m. and 2 p.m.
Answer: B, C, D
Explanation: A) Diet soda often contains caffeine and should thus be avoided.
B) Actions to prevent fluid volume deficit during the summer months include increasing fluid intake.
C) Actions to prevent fluid volume deficit during the summer months include drinking flat cola or ginger ale if vomiting.
D) Actions to prevent fluid volume deficit during the summer months include reducing the intake of caffeinated beverages like coffee and tea.
E) Exercising between the hours of 10 a.m. and 2 p.m. should also be avoided, as this is typically the hottest time of the day.
Page Ref: 399, 403
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Compare the risk factors for and prevention of fluid volume deficit and dehydration.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

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11) A child who weighs 33 lbs. has dehydration and is prescribed to receive 50 mL/kg of oral fluids for the next 4 hours. Which total amount of fluids in mL should the nurse provide to the client? Calculate to the nearest whole number.

________ mL

Answer: 750

Explanation: For children with mild to moderate dehydration, oral rehydration therapy is the first intervention, given in frequent, small amounts. For the first 2-4 hours of treatment, 50 mL of fluid for each kilogram of weight should be the target intake. The child weighs 33 lbs, so the first step in determining the total amount of fluid required is to convert this weight to kg by dividing 33 lbs. by 2.2, which yields a weight of 15 kg. The next step is to multiply the volume of fluid by the weight in kg: 50 mL × 15 = 750 mL. Thus, the nurse should provide 750 mL of fluid to the child over 4 hours.

Page Ref: 403

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Differentiate considerations for care of patients with fluid volume deficit and dehydration across the lifespan.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

12) The nurse identifies a problem of impaired skin integrity as applicable for a client diagnosed with heart failure. Which assessment finding did the nurse use to identify this problem?

A) Shortness of breath with ambulation
B) Productive cough
C) +3 pitting edema both feet
D) Heart rate 104 and regular

Answer: C

Explanation: A) Inability to tolerate activity would be appropriate for shortness of breath with ambulation.
B) Impaired gas exchange would be the problem for a productive cough.
C) Edema of the feet increases the client's risk for impaired skin integrity.
D) A problem with tissue perfusion would be appropriate for a heart rate of 104 and regular.

Page Ref: 410

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Apply the nursing process in providing culturally competent care to an individual with fluid volume excess.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

13) A client diagnosed with heart failure is prescribed an oral fluid restriction of 1200 mL per day. Which amount of fluid in ounces would the client be permitted during the day shift?

A) 200 mL
B) 300 mL
C) 400 mL
D) 600 mL

Answer: D

Explanation: A) When calculating a fluid restriction, 50% of the total daily fluid allowance should be allocated to the day shift. The amount of 200 mL would be given over the night shift.

B) When calculating a fluid restriction, 50% of the total daily fluid allowance should be allocated to the day shift. The amount of 300 mL would be given during the evening shift.

C) The amount of 400 mL would not be any amount given during the fluid restriction.

D) When calculating a fluid restriction, 50% of the total daily fluid allowance should be allocated to the day shift. The remaining 50% can be either divided equally between the evening and night shifts, or 33% of the remaining volume can be provided on the evening shift with the balance provided during the night shift. Thus, for a fluid restriction of 1200 mL, the client would be permitted 600 mL of fluid during the day shift.

Page Ref: 408

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Apply the nursing process in providing culturally competent care to an individual with fluid volume excess.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

14) The nurse is instructing a client diagnosed with heart failure about a prescribed sodium-restricted diet. Which client statement indicates that additional teaching is required?

A) "I can use as much salt substitute as I want."

B) "I have to read the labels on foods to find out the sodium content."

C) "I have to limit the intake of food with baking soda or baking powder."

D) "I can use spices and lemon juice to add flavor to food when cooking."

Answer: A

Explanation: A) Low-sodium salt substitutes are not really sodium-free; they may contain half as much sodium as regular salt. The client should be instructed to use salt substitutes sparingly because larger amounts often taste bitter instead of salty.

B) Clients should be instructed to read food labels for the amount of sodium in the food item.

C) Baking soda and baking powder contain sodium, so intake should be limited when on a sodium-restricted diet.

D) In place of salt or salt substitutes, the client should be instructed to use herbs, spices, lemon juice, vinegar, and wine as flavoring when cooking.

Page Ref: 409

Cognitive Level: Analyzing

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Apply the nursing process in providing culturally competent care to an individual with fluid volume excess.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

15) The nurse is reviewing electrolyte imbalances. Which mineralocorticoid will the nurse identify that assists in regulating the body's serum sodium balance?

A) Antidiuretic hormone
B) Parathyroid hormone
C) Aldosterone
D) Progesterone

Answer: C

Explanation: A) When extracellular fluid (ECF) osmolality increases, antidiuretic hormone is secreted, leading to additional water reabsorption.

B) Parathyroid hormone helps control calcium level.

C) Aldosterone is the principal mineralocorticoid that assists in regulating serum sodium balance. It does this by stimulating the kidneys to conserve sodium and to excrete potassium when serum sodium levels fall below normal. Water follows the sodium, and blood volume rises.

D) Progesterone is a reproductive hormone.

Page Ref: 412

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Describe the etiology of fluid volume deficit and dehydration.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

16) The nurse is asked to explain hypercalcemia. Which information will the nurse provide?
A) Hypercalcemia is often a result of hyperparathyroidism, because the increased levels of parathyroid hormone associated with this condition cause an increase in the amount of calcium in the blood.
B) Hypercalcemia is often a result of hyperparathyroidism, because the decreased levels of parathyroid hormone associated with this condition cause an increase in the amount of calcium in the blood.
C) Hypercalcemia is often a result of hypoparathyroidism, because the increased levels of parathyroid hormone associated with this condition cause an increase in the amount of calcium in the blood.
D) Hypercalcemia is often a result of hypoparathyroidism, because the decreased levels of parathyroid hormone associated with this condition cause an increase in the amount of calcium in the blood.
Answer: A
Explanation: A) Calcium levels are controlled in part by parathyroid hormone; when levels of this hormone rise, so do serum calcium levels. Hyperparathyroidism is a condition characterized by an overactive parathyroid gland. Excessive activity of this gland leads to the secretion of abnormally high amounts of parathyroid hormone, which in turn may lead to hypercalcemia.
B) Calcium levels are controlled in part by parathyroid hormone; when levels of this hormone rise, so do serum calcium levels.
C) Hyperparathyroidism is a condition characterized by an overactive parathyroid gland. Excessive activity of this gland leads to the secretion of abnormally high amounts of parathyroid hormone, which in turn may lead to hypercalcemia.
D) Hyperparathyroidism is a condition characterized by an overactive parathyroid gland. Excessive activity of this gland leads to the secretion of abnormally high amounts of parathyroid hormone, which in turn may lead to hypercalcemia.
Page Ref: 394
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Describe the pathophysiology of fluid volume deficit and dehydration.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

17) The nurse is reviewing fluid imbalances. Which fluid volume disturbance is caused by an increase in blood hydrostatic pressure?
A) Fluid volume excess, because the pressure would force fluid out through the lymphatic system and into the interstitial compartment.
B) Fluid volume deficit, because the pressure would force fluid out of the interstitial compartment and into the lymphatic system.
C) Fluid volume excess, because the pressure would force fluid out through the capillary walls and into the interstitial compartment.
D) Fluid volume deficit, because the pressure would force fluid out of the interstitial compartment and into the capillaries.
Answer: C
Explanation: A) The excess fluid is not forced out through the lymphatic system.
B) An increase in blood hydrostatic pressure results in fluid volume excess.
C) When extracellular fluid volume excess occurs, the increased fluid volume in the vascular compartment congests the veins. This leads to an increase in blood hydrostatic pressure. In turn, as the pressure against the sides of the capillaries increases, more fluid enters the interstitial compartment, causing further fluid volume excess.
D) An increase in blood hydrostatic pressure results in fluid volume excess.
Page Ref: 405
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.A. Analyze fluid and electrolyte imbalance and their effects on the body. Describe the pathophysiology of fluid volume excess.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with a fluid and electrolyte imbalance.

Exemplar 6.B Acute Kidney Injury

1) A client with acute kidney asks if a kidney transplant is needed. Which response should the nurse make?
A) "No, don't think that. You're going to be fine."
B) "In most cases, your condition can be reversed with prompt treatment and usually will not destroy the kidneys."
C) "Kidney transplantation is highly likely, so it would be a good idea to start talking to your family members about organ donation."
D) "When the doctor comes to see you, we can talk about whether you will need a transplant."
Answer: B
Explanation: A) Telling the client that everything will be fine is condescending, provides no information, and is not within the nurse's ability to know.
B) AKI is often resolved without the need for transplant if treatment is initiated quickly.
C) There is no need to start lining up donors.
D) There is no need to wait for the provider to arrive to explore options.
Page Ref: 421
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Apply the nursing process in providing culturally competent care to an individual with acute kidney injury.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

2) The nurse reviews a client's medical history and determines that the client is at risk for acute kidney injury (AKI). Which items in the client's history support this conclusion? **Select all that apply.**
A) Dehydration
B) Renal calculi
C) Ineffective wound healing
D) Low serum albumin
E) Hypertension
Answer: A, B, E
Explanation: A) Dehydration can precipitate AKI.
B) Renal calculi can precipitate AKI.
C) Ineffective wound healing does not cause AKI.
D) A low serum albumin does not cause AKI.
E) Hypertension can precipitate AKI.
Page Ref: 419
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Compare the risk factors for and prevention of acute kidney injury.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

3) The parents of a young school-age client with an acute kidney injury after a streptococcus infection asks what caused the child to be so ill. Which response should the nurse make?
A) "Your child does not eat enough dietary protein."
B) "Your child has a congenital defect that led to renal failure."
C) "Your child's renal failure has been caused by a low calcium level."
D) "Your child's recent infection may have caused the renal failure."
Answer: D
Explanation: A) A low-protein diet does not cause AKI.
B) The child has no evidence of a congenital defect.
C) A low-calcium diet will not cause AKI.
D) Clients with streptococcus are at risk for kidney and cardiac sequelae.
Page Ref: 4428
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Differentiate considerations for care of patients with acute kidney injury across the lifespan.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

4) The nurse notes that a client with acute kidney injury (AKI) has a problem of excess fluid volume. Which assessment data supports this problem?
A) Pitting edema in the lower extremities
B) Bowel sounds positive in four quadrants
C) Wheezing in the lungs
D) Generalized weakness
Answer: A
Explanation: A) The client in acute kidney injury (AKI) will likely be edematous, because the kidneys are not producing urine.
B) Bowel sounds in four quadrants is a normal assessment finding.
C) Wheezing in the lungs is an assessment consistent with asthma, not AKI.
D) Generalized weakness may be due to whatever disease process precipitated the kidney failure.
Page Ref: 428
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | Nursing Process: Evaluation
Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Identify the clinical manifestations of acute kidney injury.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

5) A client diagnosed with acute kidney injury (AKI) is receiving peritoneal dialysis. Which statement should the nurse make when explaining the process to the client and family?
A) "The peritoneum is more permeable because of the presence of excess metabolites."
B) "The metabolites will diffuse from the interstitial space to the bloodstream mainly through diffusion and ultrafiltration."
C) "The peritoneum acts as a semipermeable membrane through which wastes move by diffusion and osmosis."
D) "The solutes in the dialysate will enter the bloodstream through the peritoneum."
Answer: C
Explanation: A) The peritoneum is not more permeable because of excess metabolites.
B) Metabolic waste products and excess water can be eliminated through osmosis and diffusion using the peritoneum as the semipermeable membrane.
C) The peritoneum acts as a semipermeable membrane, allowing substances to move from an area of high concentration (the blood) to an area of lower concentration (the dialysate). Metabolic waste products and excess water can be eliminated through osmosis and diffusion using the peritoneum as the semipermeable membrane.
D) The solutes in the dialysate do not enter the bloodstream.
Page Ref: 426
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with acute kidney injury.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

6) The nurse is caring for a client diagnosed with acute kidney injury (AKI). When reviewing the client's laboratory data, which findings should indicate to the nurse that the client has met the expected outcomes? **Select all that apply.**

A) Decreasing serum creatinine
B) Decreasing blood urea nitrogen (BUN)
C) Decreasing neutrophil count
D) Decreasing lymphocyte count
E) Decreasing erythrocyte count

Answer: A, B

Explanation: A) Creatinine is the metabolic end product of creatine phosphate and is excreted via the kidneys in relatively constant amounts.
B) BUN, a measurement of the nitrogen portion of urea, is also excreted in urine and is a good indicator of renal function.
C) Neutrophils are not used to monitor the return of renal function.
D) Lymphocytes are not used to monitor the return of renal function.
E) Erythrocytes are not used to monitor the return of renal function.

Page Ref: 430
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with acute kidney injury.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

7) The nurse is caring for a client receiving hemodialysis. For which complication will the nurse assess this client?
A) Hemorrhage
B) Hypotension
C) Localized infection
D) Hypertension
Answer: B
Explanation: A) Bleeding is another possible complication, although it does not occur as often as hypotension.
B) Hypotension is the most frequent complication during hemodialysis. It may result from changes in serum osmolality, rapid removal of fluid from the vascular compartment, vasodilation, and other factors.
C) Infection is also commonly associated with hemodialysis, although it occurs following treatment rather than during dialysis.
D) Hypertension is not a complication of hemodialysis.
Page Ref: 424
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with acute kidney injury.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

8) The nurse provides dietary teaching to a client with acute kidney injury (AKI). Which statement indicates that teaching about proteins with high biological value was effective?

A) "I will be sure to include eggs in my diet."
B) "I should include vegetables at every meal."
C) "Legumes should be included in my diet, because they are complete proteins."
D) "I will eat nuts daily because they are high in protein."

Answer: A

Explanation: A) Eggs are an excellent source of essential amino acids and are recommended as part of the diet for a client with acute kidney injury (AKI) who is on a protein-restricted diet.
B) Vegetables do contain protein, but they are incomplete proteins and thus not as good a protein source as eggs.
C) Legumes contain protein, but they are incomplete proteins and thus not as good a protein source as eggs.
D) Nuts contain protein, but they are incomplete proteins and thus not as good a protein source as eggs.

Page Ref: 423

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Apply the nursing process in providing culturally competent care to an individual with acute kidney injury.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

9) The nurse is planning care for a client admitted with a diagnosis of heart failure. Based on this diagnosis, which type of kidney failure is the client at an increased risk for experiencing?
A) Prerenal hypovolemia
B) Intrarenal glomerular injury
C) Intrarenal acute tubular necrosis
D) Prerenal low cardiac output
Answer: D
Explanation: A) Causes of prerenal kidney failure due to hypovolemia include hemorrhage, dehydration, burns, wounds, and excess fluid loss from the gastrointestinal tract.
B) Causes of intrarenal kidney failure due to glomerular injury include glomerulonephritis, disseminated intravascular coagulation, vasculitis, hypertension, toxemia of pregnancy, and hemolytic uremic syndrome.
C) Causes of intrarenal kidney failure due to acute tubular necrosis include ischemia resulting from conditions associated with prerenal failure, toxins, hemolysis, and rhabdomyolysis.
D) Heart failure is one possible cause of prerenal kidney failure due to low cardiac output.
Page Ref: 417
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Apply the nursing process in providing culturally competent care to an individual with acute kidney injury.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

10) The nurse is concerned that an older adult client is at risk for developing acute kidney injury (AKI). Which data in the client's history supports the nurse's concern? **Select all that apply.**
A) Diagnosed with hypotension
B) Recent aortic valve replacement surgery
C) Prescribed high doses of intravenous antibiotics
D) Total hip replacement surgery 5 years ago
E) Taking medication for type 2 diabetes mellitus
Answer: A, B, C
Explanation: A) Older adults develop acute kidney injury more frequently because of the higher incidence of hypotension.
B) Older adults develop acute kidney injury more frequently because of the higher incidence of major surgeries.
C) Older adults develop acute kidney injury more frequently because of the higher incidence of treatment with nephrotoxic drugs.
D) A previous history of hip replacement surgery is not a risk factor for the development of acute kidney injury.
E) Current treatment for type 2 diabetes mellitus is not a risk factor for the development of acute kidney injury.
Page Ref: 428
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Compare the risk factors for and prevention of acute kidney injury.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

11) A young child is experiencing a sudden onset of nausea, vomiting, and lethargy. For which clinical manifestations will the nurse suspect that the child is experiencing acute kidney injury (AKI)? **Select all that apply.**

A) Elevated blood pressure
B) Postural hypotension
C) Wheezing
D) Edema
E) Hematuria

Answer: A, D, E

Explanation: A) Clinical manifestations of AKI in children includes hypertension.
B) Postural hypotension is a manifestation of acute kidney injury in an older person.
C) Wheezing is not a manifestation of acute kidney injury.
D) Clinical manifestations of AKI in children include edema.
E) Clinical manifestations of AKI in children include gross hematuria.

Page Ref: 427

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Differentiate considerations for care of patients with acute kidney injury across the lifespan.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

12) A client diagnosed with acute kidney injury (AKI) has jugular vein distention, lower extremity edema, and elevated blood pressure. Which problem will the nurse use to guide this client's care?
A) Potential for inadequate renal perfusion
B) Fluid volume excess
C) Potential for decreased cardiac perfusion
D) Potential for infection
Answer: B
Explanation: A) Oliguria or reduced urine output would be a symptom associated with the potential for inadequate renal perfusion.
B) Jugular vein distention, edema, and elevated blood pressure are all indications of excess fluid.
C) Alterations in heart rate and rhythm would be symptoms associated with the potential for decreased cardiac perfusion.
D) The client is not demonstrating any manifestations of an infection.
Page Ref: 428
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Identify the clinical manifestations of acute kidney injury.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

13) A client agrees to receive long-term hemodialysis to treat acute kidney injury (AKI). For which surgical procedure should the nurse prepare this client?
A) Insertion of a double-lumen catheter into the subclavian artery
B) Placement of a peritoneal catheter
C) Insertion of a subarachnoid-peritoneal shunt
D) Placement of an arteriovenous fistula
Answer: D
Explanation: A) A double-lumen catheter inserted into a major artery is used as temporary vascular access for continuous renal replacement therapy.
B) A peritoneal catheter is used for peritoneal dialysis, not hemodialysis.
C) A subarachnoid-peritoneal shunt is used to remove excess cerebrospinal fluid and not for hemodialysis.
D) For long-term vascular access needed for hemodialysis, an arteriovenous (AV) fistula is created. The fistula is created by surgical anastomosis of an artery and vein, usually the radial artery and cephalic vein. It takes about a month for the fistula to mature so that it can be used for taking and replacing blood during dialysis.
Page Ref: 425
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with acute kidney injury.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

14) A client with acute kidney failure is complaining of a metallic taste in the mouth and has no appetite. Which intervention by the nurse is appropriate?
A) Provide mouth care before meals.
B) Administer an antiemetic as prescribed.
C) Restrict fluids.
D) Encourage the intake of protein, salt, and potassium.
Answer: A
Explanation: A) A metallic taste in the mouth is due to uremia. The nurse should provide mouth care before meals to reduce this taste sensation and improve the client's oral intake.
B) An antiemetic would be prescribed for nausea.
C) Restricting fluids would not reduce the metallic taste in the mouth.
D) Encouraging intake of protein, salt, and potassium would exacerbate the uremia that is causing the metallic taste in the mouth.
Page Ref: 429
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Apply the nursing process in providing culturally competent care to an individual with acute kidney injury.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

15) A client is diagnosed with recurrent urinary tract calculi. Which type of acute kidney injury (AKI) is this client at risk for developing?

A) Prerenal AKI

B) Intrinsic AKI

C) Postrenal AKI

D) Intrarenal AKI

Answer: C

Explanation: A) Prerenal AKI results from conditions that affect renal blood flow and perfusion.

B) Intrinsic AKI (also called intrarenal AKI) is characterized by acute damage to the renal parenchyma and nephrons.

C) Obstructive causes of AKI are classified as postrenal. Any condition that prevents urine excretion–including urinary tract calculi–can lead to postrenal AKI.

D) Intrarenal AKI is characterized by acute damage to the renal parenchyma and nephrons.

Page Ref: 418

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Describe the pathophysiology of acute kidney injury.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

16) The nurse is caring for a client with an acute kidney injury (AKI). Which symptom indicates to the nurse that the client is entering the maintenance phase of the condition?
A) Onset of metabolic acidosis
B) Onset of diuresis
C) Increase in glomerular filtration rate
D) Decrease in serum potassium levels
Answer: A
Explanation: A) The maintenance phase of AKI is characterized by a significant fall in glomerular filtration rate (GFR) and tubular necrosis. Oliguria, azotemia, fluid retention, electrolyte imbalances, and metabolic acidosis may all develop.
B) Onset of diuresis indicates the recovery phase of AKI.
C) Increasing glomerular filtration rate is associated with the recovery phase of AKI.
D) During the maintenance phase, impaired potassium excretion leads to hyperkalemia, or increased serum potassium levels.
Page Ref: 419
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Identify the clinical manifestations of acute kidney injury.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

17) The nurse is caring for a client with acute kidney injury (AKI). Which laboratory finding indicates that the condition is a result of glomerular damage?

A) Hyperkalemia

B) Proteinuria

C) Urine specific gravity of 1.010

D) Moderate anemia

Answer: B

Explanation: A) Hyperkalemia is common in AKI regardless of the cause.

B) Proteinuria, or excess protein in the urine, is suggestive of glomerular damage as the cause of a client's AKI.

C) Urine specific gravity of 1.010 is common in AKI regardless of the cause.

D) Moderate anemia is common in AKI regardless of the cause.

Page Ref: 421

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with acute kidney injury.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

18) The nurse is caring for a client with acute kidney injury (AKI). Which medication will the nurse expect to be prescribed to increase renal blood flow in this client?
A) Furosemide (Lasix)
B) Mannitol (Osmitrol)
C) Bumetanide (Bumex)
D) Dopamine (Intropin)
Answer: D
Explanation: A) In clients with acute kidney injury, dopamine (Intropin) is administered in low doses by intravenous infusion to increase renal blood flow. If restoration of renal blood flow does not improve urinary output, a potent loop diuretic, such as furosemide (Lasix may be given with intravenous fluids.
B) If restoration of renal blood flow does not improve urinary output, an osmotic diuretic, such as mannitol (Osmitrol), may be given with intravenous fluids.
C) If restoration of renal blood flow does not improve urinary output, bumetanide (Bumex) may be given with intravenous fluids.
D) In clients with acute kidney injury, dopamine (Intropin) is administered in low doses by intravenous infusion to increase renal blood flow.
Page Ref: 421
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 6.B. Analyze acute kidney injury as it relates to fluids and electrolytes. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with acute kidney injury.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with acute kidney injury.

Exemplar 6.C Chronic Kidney Disease

1) The spouse of a client with chronic kidney disease (CKD) asks why the client developed anemia. Which response should the nurse make?
A) "Your spouse has a genetic tendency for the development of anemia."
B) "The increased metabolic waste products in your spouse's body depress the bone marrow and cause anemia."
C) "Your spouse's kidneys are producing reduced amounts of the hormone erythropoietin, and this is the cause of the anemia."
D) "Your spouse is not eating enough iron-rich foods, and this has led to anemia."
Answer: C
Explanation: A) There is no evidence that the client has a genetic tendency for anemia.
B) Metabolic wastes do not suppress bone marrow.
C) Anemia is common in clients with chronic kidney disease. Among the factors causing the anemia are decreased production of erythropoietin by the kidneys and shortened red blood cell (RBC) life.
D) Diet does not factor into the production of erythropoietin.
Page Ref: 434
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Identify the clinical manifestations of CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

2) A client with chronic kidney disease (CKD) reports using salt substitutes. For which reason will the nurse instruct the client to avoid this product?
A) They will increase the risk of AV fistula infection.
B) They will cause the client to retain fluid.
C) They will interact with the client's antihypertensive medications.
D) They can contribute to hyperkalemia.
Answer: D
Explanation: A) An AV fistula does need to be protected from injury and infection, but this is unrelated to use of salt substitutes.
B) Increases in weight do need to be reported to the healthcare provider as a possible indication of fluid volume excess, but this is not the reason why salt substitutes should be avoided.
C) Control of hypertension is essential in the management of a client with kidney disease, but salt substitutes are not known to interact with antihypertensive medications.
D) Many salt substitutes contain high levels of potassium chloride. Potassium intake must be carefully regulated in clients with chronic kidney disease and use of salt substitutes can worsen hyperkalemia.
Page Ref: 438
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Apply the nursing process in providing culturally competent care to an individual with CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

3) A client with chronic kidney disease (CKD) reports no bowel movements in the past 2 days. Which treatment should the nurse anticipate being prescribed to prevent hyperkalemia in this client?
A) Folic acid
B) Furosemide
C) Sodium bicarbonate
D) Potassium-ion exchange resin
Answer: D
Explanation: A) Folic acid is used to treat anemia.
B) Furosemide is used to reduce extracellular fluid volume and edema.
C) Sodium bicarbonate is used correct mild acidosis.
D) A potassium-ion exchange resin can be used to reduce the level of potassium in the client with CKD.
Page Ref: 438
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | Nursing Process: Planning
Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Differentiate considerations for care of patients with CKD across the lifespan.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

4) The nurse is planning care for a client diagnosed with chronic kidney disease (CKD) and osteoporosis. Which problem should the nurse use to guide this client's care?

A) Anxiety

B) Disturbed body image

C) Potential for injury

D) Potential for bleeding

Answer: C

Explanation: A) Anxiety is not related to osteoporosis.

B) The client on hemodialysis may have a disturbed body image, but in this case, the client is not undergoing hemodialysis.

C) The client with CKD and osteoporosis is at high risk for fractures; therefore, preventing injury should be the priority problem.

D) The client is at risk for anemia, but not bleeding.

Page Ref: 441

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Apply the nursing process in providing culturally competent care to an individual with CKD.

MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

5) A client with chronic kidney disease (CKD) is prescribed calcium acetate. Which information will the nurse provide the client about this medication?
A) "The calcium acetate will lower your serum phosphate levels."
B) "The calcium acetate helps neutralize your gastric acids."
C) "The calcium acetate will help stimulate your appetite."
D) "The calcium acetate will decrease your serum creatinine levels."
Answer: A
Explanation: A) The client with CKD has elevated phosphate levels due to the inability of the damaged kidney to excrete this electrolyte. Calcium acetate, when given with meals, will bind serum phosphorus and therefore lower the serum level.
B) Although calcium acetate can act as an antacid and neutralize gastric acid when given between meals, this is not the reason it is given to a client with CKD.
C) This medication has no effect on appetite stimulation.
D) Calcium acetate has no effect on serum creatinine.
Page Ref: 438
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Apply the nursing process in providing culturally competent care to an individual with CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

6) The nurse is preparing to administer a hemodialysis treatment for a client diagnosed with chronic kidney disease (CKD). Which laboratory values should the nurse anticipate prior to the client's treatment? **Select all that apply.**

A) Increased blood urea nitrogen (BUN)
B) Decreased potassium
C) Decreased phosphorus
D) Increased urine osmolality
E) Increased creatinine

Answer: A, E

Explanation: A) The client will have an increased blood urea nitrogen (BUN) level due to the damaged kidneys.
B) Potassium increases during renal failure due to the inability of the kidney to excrete it.
C) Phosphorus increases during renal failure due to the inability of the kidney to excrete it.
D) The damaged kidney is unable to excrete solutes; therefore, the serum osmolality will be increased and the urine osmolality will be decreased.
E) The damaged kidney is unable to excrete waste products, including creatinine, so creatinine levels will be increased.

Page Ref: 436
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

7) The nurse is evaluating whether the drug sodium polystyrene sulfonate (Kayexalate) is exerting the desired therapeutic effect for a client diagnosed with chronic kidney disease (CKD). Which therapeutic effect should the nurse anticipate from this medication?
A) Increased serum sodium
B) Increased stool excretion
C) Decreased urine specific gravity
D) Decreased serum potassium
Answer: D
Explanation: A) This drug does not affect the serum sodium level.
B) Although the client might have increased stools, the therapeutic effectiveness of the drug is measured by monitoring the serum potassium.
C) This drug does not affect the urine specific gravity.
D) The client with CKD is unable to excrete potassium. Therefore, the drug sodium polystyrene sulfonate (Kayexalate) is used in order to exchange sodium for potassium in the large intestine, resulting in decreased serum potassium levels.
Page Ref: 438
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Apply the nursing process in providing culturally competent care to an individual with CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

8) The nurse is caring for a client with chronic kidney disease (CKD). Which stage of this condition is characterized by hypertension, anemia, malnutrition, altered bone metabolism, metabolic acidosis, and a severely decreased glomerular filtration rate?
A) Stage 1
B) Stage 2
C) Stage 3
D) Stage 4
Answer: D
Explanation: A) Clients in stage 1 of chronic kidney disease (CKD) are asymptomatic and have a normal or increased glomerular filtration rate (GFR).
B) During stage 2, the GFR mildly decreases and hypertension may develop.
C) In stage 3, there is a moderate GFR decrease, as well as hypertension, possible anemia and fatigue, anorexia, possible malnutrition, and bone pain.
D) Stage 4 involves a severely decreased GFR as well as hypertension, anemia, malnutrition, altered bone metabolism, edema, metabolic acidosis, hypercalcemia, possible uremia, and azotemia.
Page Ref: 433
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Describe the pathophysiology of CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

9) A client with a history of hypertension is diagnosed with chronic kidney disease (CKD). When the client asks the nurse how this disease developed, which response should the nurse make?
A) "Thickening of the kidney structures and gradual death of nephrons has led to this diagnosis."
B) "Cysts have compressed your renal tissue and destroyed your kidneys, causing this diagnosis."
C) "High blood pressure has reduced your renal blood flow, harming the kidney tissue and causing this diagnosis."
D) "Immune complexes have formed in your kidney tissue, causing inflammation that has led to this diagnosis."
Answer: C
Explanation: A) Diabetic nephropathy causes chronic kidney disease (CKD) by thickening and sclerosis of the glomerular basement membrane and the glomerulus with a gradual destruction of nephrons.
B) Polycystic kidney disease causes CKD by multiple bilateral cysts gradually compressing renal tissue, impairing renal perfusion and leading to ischemia, which damages and destroys normal kidney tissue.
C) Long-standing hypertension leads to sclerosis and narrowing of renal arterioles and small arteries with subsequent reduction of blood flow. This leads to ischemia, glomerular destruction, and tubular atrophy.
D) Systemic lupus erythematosus causes CKD by the formation of immune complexes in the capillary basement membrane, which lead to inflammation and sclerosis.
Page Ref: 432
Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Describe the pathophysiology of CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

10) The nurse is planning a seminar to instruct community members on ways to reduce the development of chronic kidney disease (CKD). Which topics should the nurse include in the seminar? **Select all that apply.**
A) Avoid eating red meat.
B) Control blood glucose levels in diabetes mellitus.
C) Adhere to medication regimen to control hypertension.
D) Participate in regular exercise.
E) Avoid smoking.
Answer: B, C, D, E
Explanation: A) Red meat does not need to be avoided to prevent the development of CKD.
B) Prevention of CKD should focus on aggressive management of chronic disease states, especially diabetes.
C) Prevention of CKD should focus on aggressive management of chronic disease states, especially hypertension.
D) Prevention of CKD should focus on aggressive management of chronic disease states, especially diabetes and hypertension. In addition, clients should exercise regularly to prevent the development of CKD.
E) Prevention of CKD should include the avoidance of smoking.
Page Ref: 433
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Compare the risk factors for and prevention of CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

11) During a home visit, the nurse is concerned that an older adult client is developing chronic kidney disease (CKD). Which data in the client's assessment caused the nurse to have this concern? **Select all that apply.**
A) Progressive edema
B) Complaints of hip joint pain
C) New onset of hypertension
D) Recent increase in hunger and thirst
E) Warm moist skin
Answer: A, C
Explanation: A) The manifestations of chronic kidney disease (CKD) often are missed in aging clients because edema may be attributed to a preexisting cardiovascular condition.
B) Hip joint pain is not a manifestation of CKD in the older client.
C) New onset of hypertension could indicate the development of CKD in an older client.
D) An increase in hunger and thirst could be an indication of diabetes mellitus and not CKD in the older client.
E) A client with CKD will have pale dry skin with poor turgor.
Page Ref: 441
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Differentiate considerations for care of patients with CKD across the lifespan.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

12) While caring for a client diagnosed with end-stage renal disease (ESRD), the nurse tracks the client's serum albumin level. For which problem is this action most indicated?
A) Fluid volume excess
B) Undernutrition
C) Risk for inadequate renal perfusion
D) Risk for infection
Answer: B
Explanation: A) Assessing for edema would address the problem of fluid volume excess.
B) Interventions appropriate for undernutrition include monitoring laboratory values such as serum albumin.
C) Monitoring for orthostatic blood pressure changes would be appropriate for inadequate renal perfusion.
D) Monitoring the white blood cell count would be an intervention appropriate for the problem of risk for infection.
Page Ref: 442
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Apply the nursing process in providing culturally competent care to an individual with CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

13) The nurse instructs a client diagnosed with chronic kidney disease (CKD) regarding the prescribed medication furosemide (Lasix). Which client statement indicates that the teaching has been effective?

A) "I will take this medication to keep my calcium balance normal."
B) "This medication will make sure I have enough red blood cells in my body."
C) "I will take this pill to keep my protein level in my body stable."
D) "This pill will reduce the swelling in my body and get rid of the extra potassium."

Answer: D

Explanation: A) Oral phosphorus-binding agents, such as calcium carbonate or calcium acetate, are given to lower serum phosphate levels and normalize serum calcium levels.
B) Folic acid and iron supplements are given to combat anemia associated with chronic kidney disease.
C) There is no medication provided to a client with CKD that is used to stabilize protein levels in the body.
D) Furosemide (Lasix) is a loop diuretic that may be prescribed to reduce extracellular fluid volume and edema. Diuretic therapy also can reduce hypertension and cause potassium wasting, lowering serum potassium levels.

Page Ref: 438
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Apply the nursing process in providing culturally competent care to an individual with CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

14) A client with a diagnosis of chronic kidney disease (CKD) is experiencing manifestations of anemia. Which treatment should the nurse anticipate for this client?
A) Begin fluid restriction.
B) Administer intravenous glucose and insulin.
C) Begin a low-sodium diet.
D) Administer epoetin injections.
Answer: D
Explanation: A) Fluid restriction would be indicated for uremia caused by CKD.
B) Intravenous glucose and insulin may be used to reduce excessive potassium that is caused by CKD.
C) A low-sodium diet is used to help reduce fluid volume excess that is caused by CKD.
D) Epoetin injections are used in the treatment of anemia caused by CKD. This medication supplies a hormone typically created in the kidneys that signals the bone marrow to produce more red blood cells. In CKD, production of this hormone will be reduced.
Page Ref: 437
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

15) A client receiving peritoneal dialysis has a cloudy dialysate return. Which action by the nurse is the most appropriate and of highest priority?
A) Measure the client's abdominal girth.
B) Document the cloudy dialysate.
C) Culture the dialysate return.
D) Increase dialysate instillation.
Answer: C
Explanation: A) Measurement of abdominal girth is performed prior to the dialysis procedure, and increased girth could indicate peritonitis.
B) Documenting the cloudy dialysate would be a necessary nursing action but is not the next-priority action.
C) The client's dialysate return should be clear. The presence of cloudy drainage might indicate peritonitis, so the nurse should culture the return in order to help identify the presence and type of organism that could be causing the infection.
D) The instillation part of the procedure is completed prior to the collection of the dialysate return, and the rate of the instillation has no relationship to the development of an infection.
Page Ref: 443
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

16) A client received a kidney transplant 2 years ago. Which type of rejection is the client experiencing when treatment does not respond to increased immunosuppression?
A) Acute rejection
B) Chronic rejection
C) Delayed rejection
D) Nonimmune rejection
Answer: B
Explanation: A) Acute rejection develops within months of the transplant. It is caused by a cellular immune response and may be managed with methylprednisolone and OKT3 monoclonal antibody.
B) Chronic rejection, which may develop months to years following the transplant, is a major cause of graft loss. Chronic rejection does not respond to increased immunosuppression.
C) Delayed is not a type of rejection.
D) Nonimmune is not a type of rejection.
Page Ref: 440
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Identify the clinical manifestations of CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

17) The nurse is reviewing laboratory data for a client with a change in urine output. Which laboratory finding suggests the development of chronic kidney disease?
A) Increase in creatinine clearance
B) Increase in serum sodium
C) Increase in hematocrit
D) Decrease in BUN
Answer: B
Explanation: A) Laboratory findings associated with chronic kidney disease include decreased creatinine clearance due to a decrease in the glomerular filtration rate.
B) As the GFR decreases and renal function deteriorates further, sodium and water retention may occur, necessitating salt and water restrictions.
C) Hematocrit decreases due to decreased red blood cell production.
D) BUN increases due to inability of the kidneys to eliminate nitrogenous waste products.
Page Ref: 434
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Identify the clinical manifestations of CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

18) The nurse is assessing a client with chronic kidney disease (CKD). For which reason should the nurse be concerned when the client develops Kussmaul respirations?
A) It suggests the client is experiencing metabolic acidosis.
B) It suggests the client is dehydrated.
C) It suggests the client is hypotensive.
D) It suggests the client is experiencing proteinuria.
Answer: A
Explanation: A) Kussmaul respirations involve an increase in respiratory rate and depth. Clients with CKD may exhibit these respirations when they are experiencing metabolic acidosis related to impaired hydrogen ion excretion and buffer production.
B) Kussmaul respirations do not indicate dehydration in a client with CKD.
C) Kussmaul respirations do not indicate hypotension in the client with CKD.
D) Kussmaul respirations do not indicate proteinuria in a client with CKD.
Page Ref: 434
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 6.C. Analyze chronic kidney disease as it relates to fluids and electrolytes. Identify the clinical manifestations of CKD.
MNL LO: Demonstrate understanding of the concept of fluid and electrolytes in the care of a patient with chronic kidney disease.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e **(Pearson)**
Module 7 Health, Wellness, Illness, and Injury

The Concept of Health, Wellness, Illness, and Injury

1) The nurse identifies the components of wellness as a useful tool in assessing health. Which components of wellness will the nurse identify? **Select all that apply.**
A) Physical
B) Environmental
C) Emotional
D) Financial
E) Spiritual
Answer: A, B, C, D, E
Explanation: A) The physical component allows the person to engage in ADLs without experiencing undue fatigue or exhaustion. This component is supported through healthy behaviors.
B) The environmental component involves the ability to recognize one's responsibility to improve, protect, or preserve the quality of life in a community by being respectful of the surroundings.
C) The emotional component is the ability to manage stress and to express emotions appropriately.
D) Financial wellness requires effectively managing finances, spending within one's means, being prepared for emergencies, and having the tools necessary to make economic decisions.
E) The spiritual component is the belief in some force (nature, science, religion, or a higher power) that serves to unite human beings and provide meaning and purpose to life.
Page Ref: 450-451
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 7.1. Identify the dimensions of wellness and the determinants of health.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

W W . T B S M . W S

2) A nurse is preparing a workshop on the leading health indicators of population health identified by the Office of the Attorney General. Which topics should the nurse plan to address? **Select all that apply.**
A) Injury and violence
B) Genomics
C) Oral Health
D) Mental Health
E) Healthcare-Associated Infections
Answer: A, C, D
Explanation: A) Injury and violence is a leading indicator of population health in the United States.
B) Genomics is not identified as a leading indicator of population health in the United States.
C) Oral health is a leading indicator of population health in the United States.
D) Mental health is a leading indicator of population health in the United States.
E) Healthcare-Associated Infections is not identified as a leading indicator of population health in the United States.
Page Ref: 458
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 7.4. Describe the national vision of health promotion.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

3) The nurse is assessing a young adult client who was recently diagnosed as pregnant. Which factor should the nurse identify as the greatest barrier to health promotion in this client?
A) Age of the client
B) Presence of the client's mother during the appointment
C) Pregnancy occurred as a result of rape
D) First pregnancy (primigravida)
Answer: C
Explanation: A) The age of the mother could be a factor that promotes a desire for health or causes the client to make unhealthy choices, depending on the client's situation.
B) The presence of the client's mother could be a factor that promotes a desire for health or causes the client to make unhealthy choices, depending on the client's situation.
C) Clients who are pregnant as a result of rape will have both physical and emotional barriers to health promotion.
D) Gravidity could be a factor that promotes a desire for health or causes the client to make unhealthy choices, depending on the client's situation.
Page Ref: 459
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 7.4. Describe the national vision of health promotion.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

4) The nurse is preparing a presentation on health beliefs and behaviors. Which nonmodifiable risk factors for illness will the nurse include in the content? **Select all that apply.**
A) Family health history
B) Diet
C) Exercise regimen
D) Ethnicity
E) Age
Answer: A, D, E
Explanation: A) Nonmodifiable risk factors for illness include family health history.
B) Diet is a modifiable risk factor for illness.
C) Exercise is a modifiable risk factor for illness.
D) Nonmodifiable risk factors for illness include ethnicity.
E) Nonmodifiable risk factors for illness include age.
Page Ref: 461
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 7.5. Differentiate variables influencing healthy lifestyle behaviors.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

5) The nurse is teaching a class about building positive relationships and learning skills to be open-minded and respectful to those with opposing opinions. Based on this data, on which component of wellness is the nurse focusing?
A) Physical
B) Social
C) Environment
D) Emotional
Answer: B
Explanation: A) Physical wellness allows a person to engage in activities of daily living without experiencing undue fatigue and exhaustion.
B) Social wellness requires the ability to trust and respect other people and leads to the creation of supportive partnerships and friendships.
C) Environmental wellness involves the ability to recognize one's responsibility to improve, protect, or preserve the quality of life in a community by being respectful of the surroundings.
D) Emotional wellness involves recognizing, accepting, and expressing feelings.
Page Ref: 450-451
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 7.1. Identify the dimensions of wellness and the determinants of health.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

6) The nurse is providing teaching related to health promotion for a group of older adults. On which topic should the nurse focus?
A) Food safety
B) Physical activity
C) Financial stability
D) Recreational activities
Answer: B
Explanation: A) Food safety is not a health promotion priority for older adults.
B) Physical activity is a health promotion priority for older adults. Remaining active and independent improves well-being and decreases consequences of acute and chronic illnesses.
C) Financial stability is not a health promotion priority for older adults.
D) Recreation activities are not a health promotion priority for older adults.
Page Ref: 459
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 7.4. Describe the national vision of health promotion.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

7) The nurse conducts teaching for a client recently diagnosed with type 2 diabetes mellitus. At the conclusion of the session, which client statement indicates that teaching has been effective?
A) "I will take medication for a week for this acute illness."
B) "I will have to take insulin for this disease every day for the rest of my life."
C) "This acute disease will become worse and lead to death."
D) "I will have to make dietary changes to manage this chronic disease."
Answer: D
Explanation: A) Not all clients diagnosed with type 2 diabetes mellitus require medication to manage the disease process.
B) Not all clients diagnosed with type 2 diabetes mellitus require medication, such as insulin, to manage the disease process.
C) Diabetes is chronic, not acute. Depending on the client's response to the disease, the outcome may not become worse or lead to death.
D) The client is aware that dietary changes will be needed to manage this chronic disease, indicating that the client understands the teaching the nurse provided.
Page Ref: 462
Cognitive Level: Evaluating
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 7.2. Explain illness and injury, the impact of health disparities, and effects on patients, families, and communities.

MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

8) An occupational health nurse for a large corporation is planning programs to address health lifestyle behaviors. Which information will the nurse provide? **Select all that apply.**
A) Maintaining a healthy diet
B) Restricting physical activity
C) Avoiding all tobacco products
D) Drinking alcohol in moderation
E) Sleeping 7 to 9 hours each night
Answer: A, C, D, E
Explanation: A) Recommendations and rationales for healthy lifestyle behaviors include maintaining a healthy diet.
B) Recommendations and rationales for healthy lifestyle behaviors include engaging in regular physical activity.
C) Recommendations and rationales for healthy lifestyle behaviors include avoiding all tobacco products.
D) Recommendations and rationales for healthy lifestyle behaviors include drinking alcohol in moderation or not at all.
E) Recommendations and rationales for healthy lifestyle behaviors include sleeping 7 to 9 hours each night.
Page Ref: 461-462
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 7.4. Describe the national vision of health promotion.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

9) After conducting a physical assessment with an adult client, the nurse realizes the client follows health practices from an unfamiliar culture. Which action should the nurse take?
A) Repeat the assessment later in the day.
B) Determine the culture with which the client identifies.
C) Write a nursing diagnosis to address the unfamiliar beliefs and actions.
D) Communicate the findings to the healthcare team.
Answer: B
Explanation: A) Repeating the assessment will most likely result in the same data.
B) A thorough assessment that includes assessment of cultural beliefs and practices is needed before proceeding with other steps of the nursing process. Behavior that is considered uncommon in one cultural context may be considered desirable in another.
C) Writing a nursing diagnosis or communicating findings before investigating the client's culture would be premature.
D) There is no reason to share the information with others until the cultural group is identified.
Page Ref: 464
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 7.5. Differentiate variables influencing healthy lifestyle behaviors.

MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

10) The nurse is caring for a client with chronic obstructive pulmonary disease (COPD). On which health promotion concept will the nurse focus teaching?
A) Safety
B) Elimination
C) Immunity
D) Development
Answer: A
Explanation: A) COPD often develops as a result of years of smoking, and one common therapy is oxygen administration. The combination of smoking and oxygen increases the client's risk for safety related to fire hazards.
B) COPD does not commonly cause changes in elimination.
C) COPD does not commonly cause changes in immunity.
D) COPD does not commonly cause changes in development.
Page Ref: 456
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 7.3. Outline the concepts related to health, wellness, illness, and injury.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

11) The nurse cares for clients in a community clinic. Which nursing interventions exemplify the nurse working in a health promotion role? **Select all that apply.**
A) Administering a prescribed antibiotic
B) Reinforcing desirable changes to the client's lifestyle
C) Administering vaccines to a well child
D) Administering an inhaler to a client with asthma
E) Obtaining a blood glucose sample on a client with hypoglycemia
Answer: B, C
Explanation: A) Administering an ordered antibiotic exemplifies a nursing intervention that is in response to disease or illness.
B) The nurse acting in a health promotion role is performing interventions to prevent disease. Reinforcing desirable changes to the client's lifestyle is acting in a health promotion role.
C) Administering vaccines to a well child is a health promotion activity.
D) Giving medications is an act in response to an illness or disease.
E) Obtaining a blood glucose sample is done in response to disease or illness.
Page Ref: 459
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 7.4. Describe the national vision of health promotion.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

12) A community health nurse is teaching a group of clients on the difference between illness and disease. Which statements are appropriate for the nurse to include in the educational session? **Select all that apply.**

A) "An individual can have a disease and not feel ill."
B) "Illness is synonymous with disease."
C) "Illness is an alteration in body function, where disease is highly subjective."
D) "An individual can feel ill without disease."
E) "Illness and disease are never related to one another."

Answer: A, D

Explanation: A) People can feel ill without having a discernible disease.
B) Illness is not another term for disease.
C) Illness is the experience of being unhealthy or unwell. A disease is a disorder of structure or function in an organ(s) or body system(s).
D) An individual can feel ill–that is, feel uncomfortable–and yet have no discernible disease.
E) Illness symptoms and disease processes do often co-occur and are classified based on how they occur.

Page Ref: 452
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 7.2. Explain illness and injury, the impact of health disparities, and effects on patients, families, and communities.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

13) The nurse is preparing to care for a client. Which concept will the nurse use to identify habits of health and wellness and the effects of illness and injury?

A) Assessment
B) Collaboration
C) Teaching and learning
D) Advocacy
Answer: A
Explanation: A) As the first step in the nursing process, the nurse will use assessment with every client to identify habits of health and wellness and the effects of illness and injury.
B) Collaboration does not help identify healthy habits or the effects of illness and injury.
C) Teaching and learning does not help identify healthy habits or the effects of illness and injury.
D) Advocacy does not help identify healthy habits or the effects of illness and injury.
Page Ref: 467
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment
Learning Outcome: 7.3. Outline the concepts related to health, wellness, illness, and injury.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

14) The nurse is assessing a client. On which criteria will the nurse focus for health promotion activities?

A) Culture
B) Lifestyle
C) Spiritual beliefs
D) Socioeconomic status
Answer: B
Explanation: A) Culture is not an area on which to focus for health promotion.
B) Health promotion involves nursing assessment of a client's lifestyle and implementation of needed changes to that lifestyle.
C) Spiritual beliefs are not an area on which to focus for health promotion.
D) Socioeconomic status is not an area on which to focus for health promotion.
Page Ref: 461-462
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.B.10. Engage patients or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment, Assessment
Learning Outcome: 7.6. Apply the nursing process to identify health promotion needs.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

15) The nurse is reviewing data collected for a client desiring to improve current health status. Which problem statement will the nurse identify for this client?
A) Risk for illness
B) Wellness strength
C) Altered health status
D) Desire for information
Answer: B
Explanation: A) The client is not at a risk for an illness.
B) A wellness strength is willingness to make a change to improve health.
C) There is no evidence that the client has an altered health status.
D) There is no evidence that the client desires information.
Page Ref: 468
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.B.10. Engage patients or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Diagnosis
Learning Outcome: 7.6. Apply the nursing process to identify health promotion needs.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

Exemplar 7.A Physical Fitness and Exercise

1) The nurse is preparing a teaching tool about the benefits of exercise. Which impact will the nurse explain that exercise has on the gastrointestinal system?
A) Use of fatty acids
B) Insulin responsiveness
C) Enhance the gut microbiome
D) Reduction of polyp formation
Answer: C
Explanation: A) Exercise does not impact use of fatty acids.
B) Insulin responsiveness is an effect of exercise on the endocrine system.
C) Exercise has a critical role in the maintenance of gut health and metabolism. The gastrointestinal tract is inhabited by trillions of microorganisms (microbiome) that impact intestinal function. Recent studies suggest that exercise enhances the gut microbiome, which improves lipid and carbohydrate metabolism; these benefits lead to a reduction in risk of colon cancer, inflammatory bowel disease, obesity, and metabolic diseases.
D) There is no evidence that exercise impacts the development of polyps.
Page Ref: 473
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.1 Demonstrate an understanding of the discipline of nursing's distinct perspective and where shared perspectives exist with other disciplines. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 7.A. Analyze physical fitness and exercise as they relate to health, wellness, illness, and injury. Outline the effects of exercise on body systems.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

2) The nurse is providing wellness teaching to a client who is interested in beginning an exercise program to reduce certain health risks. The nurse determines that the client understands the teaching when the client selects which health risks that can be reduced by regular exercise? **Select all that apply.**

A) Liver disease
B) Type 2 diabetes
C) Cardiovascular disease
D) Dementia
E) Renal disease

Answer: B, C, D

Explanation: A) Regular physical activity does not decrease the risk of liver disease.
B) Regular physical activity results in a decreased risk of type 2 diabetes.
C) Regular physical activity results in a decreased risk of cardiovascular disease.
D) Regular physical activity results in a decreased risk of dementia.
E) Regular physical activity does not decrease the risk of renal disease.

Page Ref: 473
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 7.A. Analyze physical fitness and exercise as they relate to health, wellness, illness, and injury. Describe the benefits of physical fitness.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

3) The nurse is providing care to an older adult client who was recently diagnosed with early osteoporosis. Which intervention is most appropriate for the nurse to implement with this client?
A) Providing the client with assisted range of motion exercising twice daily
B) Instituting an exercise plan that includes weight-bearing activities
C) Protecting the client's bones with strict bedrest
D) Increasing the amount of calcium in the client's diet
Answer: B
Explanation: A) Assisted range of motion exercises are not weight bearing and do not help delay or reverse osteoporosis.
B) Osteoporosis is a demineralization of the bone in which calcium leaves the bone matrix. One causative factor is lack of weight-bearing activity. Weight bearing helps to move calcium back into the bone, thereby strengthening it. A standard intervention for those attempting to prevent or reverse osteoporosis is beginning an exercise plan that includes weight-bearing activities.
C) Strict bedrest may well make the osteoporosis worse because there is no weight-bearing activity.
D) Additional calcium in the diet after osteoporosis has begun is not thought to be effective.
Page Ref: 473
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 7.A. Analyze physical fitness and exercise as they relate to health, wellness, illness, and injury. Outline the effects of exercise on body systems.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

4) A school nurse is reviewing the physical activity for adolescent high school students. Which student has met the outcome for physical activity set by the Centers for Disease Control and Prevention (CDC)?
A) An 18-year-old who speed-walks 60 minutes once per week
B) A 16-year-old who lifts moderately heavy weights for 15 minutes 3 times per week
C) A 15-year-old who runs at a fast pace for 20 minutes 2 times per week
D) A 17-year-old who alternates aerobic activities for 60 minutes daily and lifts weights 2 times per week
Answer: D
Explanation: A) Speed walking once a week does not meet the guidelines.
B) Lifting weights for 15 minutes 3 times a week does not meet the guidelines.
C) Running for 20 minutes 2 times a week does not meet the guidelines.
D) The recommendations for physical activity for adolescents are 60 minutes of physical activity almost every day, with vigorous activity at least 3 days per week and inclusion of muscle strengthening activities.
Page Ref: 474
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 7.A. Analyze physical fitness and exercise as they relate to health, wellness, illness, and injury. Summarize the recommendations for physical activity across the lifespan.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

5) The pulmonary rehabilitation nurse is teaching a group of clients about both isotonic and isometric exercises. At the conclusion of the session, which client statements indicate effective teaching has occurred? **Select all that apply.**

A) "Isotonic exercises require muscle movement."
B) "Isotonic exercises build bone density."
C) "Isometric exercises can be adapted for mobility-impaired individuals."
D) "Isotonic exercises produce a mild increase in heart rate and cardiac output, but no appreciable increase in blood flow to other parts of the body."
E) "Isometric exercises are a controlled form of strength training."

Answer: A, B, C, E

Explanation: A) Isotonic exercises are exercises that require muscle movement.
B) Isotonic exercises build bone density.
C) Isometric exercises strengthen and stretch the body, and they can be safely adapted for individuals who are mobility-impaired.
D) Isometric exercises produce a mild increase in heart rate and cardiac output.
E) Isokinetic exercises are a controlled form of strength training.

Page Ref: 471-472
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 7.A. Analyze physical fitness and exercise as they relate to health, wellness, illness, and injury. Contrast the types of exercise.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

6) The nurse is preparing a teaching tool about exercise for a community health fair. Which categories of exercise should the nurse include in this tool? **Select all that apply.**
A) Interval
B) Adapted
C) Strength
D) Flexibility
E) Endurance
Answer: A, C, D, E
Explanation: A) Interval training is alternating short bursts of higher-intensity activity into a sustained aerobic workout.
B) Adapted is not a category of exercise.
C) Strength training are exercises that use resistance to strengthen muscle groups.
D) Flexibility training is the use of exercises intended to improve muscle elasticity and length, joint structure, and balance.
E) Endurance training are aerobic activities that increase heart rate, respiratory rate, and metabolism.
Page Ref: 471
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 7.A.2. Analyze physical fitness and exercise as they relate to health, wellness, illness, and injury. Contrast the types of exercise.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

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7) The nurse is planning physical fitness and exercise recommendations for a 27-year-old pregnant woman at 16 weeks' gestation. Which recommendation should the nurse make?
A) Restrict activity to twice a week.
B) Obtain 150 minutes of moderate-intensity aerobic activity each week.
C) Focus on walking as the main activity.
D) Use a stationary bicycle for physical activity.
Answer: B
Explanation: A) There is no need to restrict activity to twice a week when pregnant.
B) Pregnant women should engage in at least 150 minutes of moderate physical activity each week. They can engage in vigorous physical activity if that is already part of their routine.
C) Walking does not need to be the main activity.
D) A stationary bicycle does not need to be used for physical activity when pregnant.
Page Ref: 474
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.B.10. Engage patients or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 7.A. Analyze physical fitness and exercise as they relate to health, wellness, illness, and injury. Summarize the recommendations for physical activity across the lifespan.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

Exemplar 7.B Oral Health

1) During a well-child checkup, the parent of a young school-age child reports that well water is used in their community. Which statement should the nurse prioritize when teaching?
A) "Your child will need to use a teeth whitener in the future because well water is your primary water source."
B) "Your child will need to be placed on a fluoride supplement because your primary water source is from a well."
C) "I will recommend some mouthwashes that are appropriate for clients who drink well water."
D) "It will be very important that your child does not eat sugary foods because you drink well water."
Answer: B
Explanation: A) Teeth whitener is not required for a child who drinks well water.
B) Inquire about use of fluoride if the water supply is not fluoridated. Well water does not contain fluoride.
C) Special mouthwashes are not required for a child who drinks well water.
D) Refraining from sugary foods is not necessary just because the child's primary drinking source is from a well.
Page Ref: 477
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 7.B. Analyze oral health as it relates to health, wellness, illness, and injury. Describe the significance of oral hygiene across the lifespan.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

2) The nurse is reviewing the anatomy and physiology of the teeth with a group of students. Which part of the tooth should the nurse identify that wears away, allowing dental decay?
A) Pulp cavity
B) Enamel
C) Gingiva
D) Root
Answer: B
Explanation: A) The pulp cavity can become damaged after the enamel has worn away.
B) Enamel is a hard substance that covers the outside of the tooth to protect it from damage and decay. Enamel wears away over time, allowing dental damage and decay in the form of dental caries.
C) Gingiva is another term for gums; the gums are not part of the teeth but instead help cover the roots and hold the teeth in place.
D) Roots can become damaged after the enamel has worn away.
Page Ref: 476
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 7.B. Analyze oral health as it relates to health, wellness, illness, and injury. Describe the functions of the oral cavity and normal oral health.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

3) A client in the intensive care unit who is intubated and mechanically ventilated has cheilosis. Which action should the nurse take?
A) Check for ill-fitting dentures
B) Suggest an increase in fluid intake
C) Provide oral care
D) Lubricate the lips using an antimicrobial ointment
Answer: D
Explanation: A) The client would not have dentures in place when intubated.
B) Suggesting an increase to the client's fluid intake would be appropriate for a client with dry mucous membranes.
C) Oral care will not help cheilosis.
D) Cheilosis is when the lips are cracked. The priority nursing intervention for this client is to lubricate the lips with antimicrobial ointment to prevent infection.
Page Ref: 477
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 7.B. Analyze oral health as it relates to health, wellness, illness, and injury. Identify commonly occurring alterations in oral health.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

4) The nurse is caring for a client with glossitis secondary to nutritional deficiencies. Based on this data, which is the priority focus of this client's care?
A) Upper lip
B) Upper teeth
C) Uvula
D) Tongue
Answer: D
Explanation: A) Glossitis is the inflammation of the tongue and does not involve the lips.
B) Glossitis is the inflammation of the tongue and does not involve the teeth.
C) Glossitis is the inflammation of the tongue and does not involve the uvula.
D) Glossitis is the inflammation of the tongue.
Page Ref: 477
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 7.B. Analyze oral health as it relates to health, wellness, illness, and injury. Identify commonly occurring alterations in oral health.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

5) A pediatric nurse is caring for a toddler at a well-child clinic. When providing education regarding the client's oral health, which topics are appropriate for the nurse to include? **Select all that apply.**

A) Instructions on avoiding prolonged bottle feeding during naps and at bedtime.
B) Instructions on brushing the client's teeth once daily.
C) Hazards of fluoride use in tooth development.
D) Instructions on eliminating the client's milk consumption.
E) Instructing the parents that the client needs dental care prior to when the client begins to lose the primary teeth.

Answer: A, E

Explanation: A) Prolonged bottle feeding should be avoided because it can contribute to dental caries.
B) The client's teeth should be brushed after meals.
C) Fluoride should be used for those with non-fluoridated water and does not pose a risk in tooth development.
D) The client does not need to eliminate milk consumption.
E) Many parents are unaware of the importance of dental health in very young children. They may see their child's teeth as "baby teeth" and think they can put off dental visits until the child begins to lose the primary teeth. Nurses working with parents of very young children may need to help the parents learn that care of primary teeth is essential to healthy permanent teeth.

Page Ref: 477
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 7.B. Analyze oral health as it relates to health, wellness, illness, and injury. Describe the significance of oral hygiene across the lifespan.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

6) The nurse is working with a family that is new to the pediatric practice. Which topics will the nurse include when teaching the mother how to decrease the development of dental caries in an infant? **Select all that apply.**
A) Refraining from giving the infant a bottle for a prolonged time at bedtime
B) Giving the infant sugar water only at breakfast time
C) Wiping the infant's gums with soft moist gauze once or twice daily
D) Using a toothbrush as soon as the first tooth erupts
E) Using a topical anesthetic daily, beginning as soon as the first tooth begins to erupt
Answer: A, C
Explanation: A) Interventions appropriate for prevention of dental caries include avoiding prolonged bottle feeding at bedtime.
B) Foods high in sugar should be avoided for the infant at all times.
C) Interventions appropriate for prevention of dental caries include wiping the gums with a soft moist gauze.
D) A toothbrush should not be used during infancy.
E) Topical anesthetic should not be applied daily.
Page Ref: 477
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 7.B. Analyze oral health as it relates to health, wellness, illness, and injury. Describe the significance of oral hygiene across the lifespan.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

7) The nurse is caring for a client in a long-term care facility. Which expected outcome should the nurse identify when the client has difficulty completing self-care?
A) The client will be able to name the staff that works on the day shift.
B) The client, with supervision, will brush teeth twice per day.
C) The client will eliminate safety hazards in the environment.
D) The nurse will stress the importance of adequate fluid intake.
Answer: B
Explanation: A) Naming the staff will not help with self-care.
B) A client with cognitive impairment would be able to brush the teeth, but only with supervision. The client would not voluntarily brush the teeth without prompting from the staff.
C) Eliminating safety hazards will not help with self-care.
D) An adequate fluid intake will not help with self-care.
Page Ref: 480
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 7.B. Analyze oral health as it relates to health, wellness, illness, and injury. Outline nursing management of oral health including identifying patients at risk and promoting oral hygiene.

MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

Exemplar 7.C Normal Sleep-Rest Patterns

1) The nurse notes that during sleep, an acutely ill client has blood pressure, heart rate, and respirations below baseline. Which conclusion should the nurse make regarding this information?
A) The client is about to have a cardiac arrest.
B) The client is in NREM sleep.
C) The client's metabolic rate has increased.
D) The client is in REM sleep.
Answer: B
Explanation: A) The client is not necessarily at risk for cardiac arrest.
B) During NREM sleep, the client is relaxed, and body functions are decreased. A decrease in vital signs is normal during NREM sleep.
C) During NREM sleep, body functions are decreased, including metabolic rate.
D) REM sleep is characterized by increased body function and elevated vital signs.
Page Ref: 482
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 7.C. Analyze sleep and rest as they relate to health, wellness, illness, and injury. Describe the physiology and functions of sleep.

MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

2) A new mother is concerned that the baby's "eyes dart around the eyelids and has irregular breathing" when asleep. Which response should the nurse make?
A) "Please bring your baby in immediately for a checkup."
B) "You should ask the doctor about these symptoms at your next checkup."
C) "These are common behaviors in newborns and are normal."
D) "If your baby does this again, take her to the emergency department."
Answer: C
Explanation: A) There is no need for an immediate checkup.
B) Having the mother wait until the next checkup unnecessarily delays this reassurance.
C) These are indications of normal REM sleep in the newborn. The mother should be reassured that this is normal.
D) There is no need for an immediate trip to the emergency department.
Page Ref: 483
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 7.C. Analyze sleep and rest as they relate to health, wellness, illness, and injury. Describe variations in sleep patterns across the lifespan.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

3) A client reports having difficulty sleeping. Which recommendation should the nurse make for this client?
A) Eat a small snack before bedtime.
B) Take an over-the-counter sleep aid such as melatonin.
C) Set a routine time to go to bed and a routine time to get out of bed.
D) Do a calming activity in bed before trying to sleep, such as reading a book.
Answer: C
Explanation: A) Eating a small snack before bed is not recommended to promote sleep.
B) Although taking an over-the-counter sleep aid may help promote sleep, it should not be a first-line treatment recommendation.
C) The most important change to make in a bedtime routine is to set a routine mandatory time to go to bed and set a routine mandatory time to get out of bed. The client needs to train his mind and body to expect to sleep on this schedule.
D) Using the bed for activities other than sleep and sex are not recommended to promote sleep.
Page Ref: 485
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 7.C. Analyze sleep and rest as they relate to health, wellness, illness, and injury. Plan interventions that promote normal sleep.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

4) The parent of an adolescent client expressed concern regarding the adolescent's sleeping habits. Which assessment findings indicate to the nurse that the adolescent client is sleep deprived? **Select all that apply.**
A) Consumption of caffeinated soda
B) Difficulty waking in the morning for school
C) Irritability and anxiety, especially on days with less sleep
D) Trouble initiating or persisting in projects, such as school assignments
E) Refusal to participate in sports activities
Answer: A, B, C, D
Explanation: A) High caffeine consumption is associated with a variety of adolescent health issues like insomnia, which can lead to sleep deprivation.
B) Sleep deprivation may cause the adolescent to have trouble waking in the morning for school.
C) Other symptoms of sleep deprivation include irritability and anxiety.
D) Other symptoms of sleep deprivation include problems associated with attention, memory, and decision making.
E) Sports participation is not correlated to sleep deprivation.
Page Ref: 484
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 7.C. Analyze sleep and rest as they relate to health, wellness, illness, and injury. Describe variations in sleep patterns across the lifespan.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

5) An adult client asks for suggestions to improve sleep. Which recommendations should the nurse make? **Select all that apply.**
A) Limit the use of alcohol to early in the evening
B) Have a cup of tea before bed in order to enhance relaxation
C) Adjust the room temperature to a comfortable level for sleep
D) Change the time of aerobic exercise to 1 hour prior to sleep
E) Limit cigarette smoking before bedtime
Answer: A, C, E
Explanation: A) Alcohol interferes with REM sleep, and its consumption should be limited to well before bedtime.
B) Tea contains caffeine, which is a stimulant. The nurse could suggest non-caffeinated tea before bedtime unless this causes the client to wake during the night to urinate.
C) A comfortable room temperature will promote sleep.
D) Exercise close to bedtime acts as a stimulant and can cause the client to be unable to sleep.
E) Nicotine is a stimulant and may prevent the client from falling asleep.
Page Ref: 485
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 7.C. Analyze sleep and rest as they relate to health, wellness, illness, and injury. Outline factors affecting sleep.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

6) The nurse is caring for a newborn who is sleeping. Which information about sleep in a newborn is inaccurate?
A) A newborn will have an irregular sleep schedule with periods of 1-3 hours spent awake.
B) NREM sleep in a newborn is characterized by regular respirations, closed eyes, and the absence of body and eye movements.
C) REM sleep occurs gradually in a newborn.
D) NREM sleep is also called quiet sleep during the newborn period.
Answer: C
Explanation: A) Newborns sleep on an irregular schedule with periods of 1-3 hours spent awake.
B) NREM sleep is characterized by regular respirations, closed eyes, and the absence of body and eye movements.
C) Unlike older children and adults, newborns enter REM sleep immediately.
D) NREM sleep is also called quiet sleep during the newborn period.
Page Ref: 482-483
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 7.C. Analyze sleep and rest as they relate to health, wellness, illness, and injury. Describe variations in sleep patterns across the lifespan.
MNL LO: Analyze the concept of health, wellness, and illness and its application to nursing care.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e **(Pearson)**
Module 8 Immunity

The Concept of Immunity

1) A client with a systemic infection asks which defenses the body has against infection. Which physiologic barriers should the nurse include in the response to the client? **Select all that apply.**
A) The spleen
B) Adequate urinary output
C) Intact skin
D) Generalized inflammation
E) The thymus gland
Answer: B, C
Explanation: A) The spleen is part of the immune system; however, it is not a physiologic barrier but rather an internal organ in which lymphoid cells proliferate and/or mature.
B) The membranes lining the inner surfaces of the body are protected by a barrier of mucus, which traps microorganisms and other foreign substances. These can then be removed by other protective mechanisms, such as the washing action of urine.
C) Barrier protection is the body's first line of defense against infection. The skin is the primary barrier; when intact, it prevents invasion by external organisms.
D) Although the inflammatory response helps fight infection, it occurs when the body's physiologic barriers to microorganisms have already been breached.
E) The thymus gland is an internal organ of the immune system; however, it is not considered a physiologic barrier.

Page Ref: 496
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.1 Demonstrate an understanding of the discipline of nursing's distinct perspective and where shared perspectives exist with other disciplines. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.1. Analyze the physiology of immunity in the body.
MNL LO: Analyze the concept of immunity and its application to nursing care.

2) A client who receives a vaccination of a live virus before foreign travel asks how the vaccine provides protection. Which responses by the nurse are most appropriate? **Select all that apply.**
A) "Human macrophages engulf the weakened vaccine virus as if it is dangerous, and antigens stimulate the immune system to attack it."
B) "In the lymph nodes, which are part of the lymphoid system, the macrophages present antigens of the virus to T cells and B cells."
C) "A response from yellow fever—specific T cells is activated. B cells secrete yellow fever antibodies."
D) "The vaccine contains large amounts of protective antibodies that were produced in another host organism, so it provides immediate protection against yellow fever."
E) "The initial weak infection is eliminated, and the client is left with a supply of memory T and B cells for future protection against yellow fever."
Answer: A, B, C, E
Explanation: A) Administration of the vaccine introduces a small number of weakened viruses into the body. Macrophages ingest these viruses while also presenting the viruses' antigens to T cells and B cells.
B) Exposure to the antigens causes the T cells to attack the viruses.
C) Exposure to the antigens triggers the B cells to begin secreting antibodies, which attack and destroy the antigens.
D) In this way, vaccination leads to the development of active immunity, unlike administration of large amounts of antibodies that were produced in another host, which is a type of passive immunity.
E) The initial weak infection is eliminated, and the body is left with a supply of memory T and B cells that provide future protection against the virus.

Page Ref: 506
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.1. Analyze the physiology of immunity in the body.
MNL LO: Analyze the concept of immunity and its application to nursing care.

3) The nurse is caring for clients in the emergency department. Which client demonstrates a declining immune response that typically occurs with the aging process?
A) An 88-year-old client with pneumonia who has a temperature of 99.5°F
B) A 70-year-old client who has swelling and redness around an abdominal incision from an open appendectomy
C) A 58-year-old client who complains of redness and itching after developing a rash from contact with poison ivy
D) A 56-year-old client who has 8 mm induration at the site of a PPD skin test administered 72 hours earlier
Answer: A
Explanation: A) The client who has only a slight elevation in temperature in response to pneumonia is exhibiting a decline in the expected immune response.
B) Swelling and redness is an expected immune response.
C) Redness is an expected immune response.
D) Induration is an expected immune response.
Page Ref: 496
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 8.8. Differentiate considerations related to the assessment and care of patients with alterations in immunity throughout the lifespan.
MNL LO: Analyze the concept of immunity and its application to nursing care.

4) The nurse is conducting a physical assessment for a client with a compromised immune system. Which actions by the nurse are appropriate? **Select all that apply.**
A) Assessing general appearance
B) Recommending increased fluid intake
C) Inspecting the mucous membranes of the nose and mouth
D) Palpating the cervical lymph nodes
E) Checking joint range of motion (ROM), including that of the spine
Answer: A, C, D, E
Explanation: A) Before conducting the interview, the nurse should review the client's biographical data, including age, sex, race, and ethnic background. The nurse would then observe the general appearance of the client and note whether the client's stated and apparent age coincide.
B) Although recommending that the client increase fluid intake may be an appropriate intervention, it is not an action that is conducted during the physical assessment for this client.
C) The mucous membranes of the nose and mouth should be inspected for color and condition.
D) The cervical lymph nodes should be palpated for swelling or tenderness.
E) The client's ROM, including that of the spine should be assessed.
Page Ref: 509-511
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 8.5. Differentiate common assessment procedures and tests used to examine immune function.
MNL LO: Analyze the concept of immunity and its application to nursing care.

5) A client seeks medical attention for a foot infection caused by stepping on a rusty nail. Which treatment option does the nurse anticipate for this client?

A) Toxoid

B) Live virus vaccine

C) Inactivated virus vaccine

D) Recombinant form vaccine

Answer: A

Explanation: A) A toxoid vaccine is created by treating a microorganism toxin with heat or chemical to weaken the toxic effects but retain antigenicity. Boosters are typically required to maintain ongoing protection against diseases.

B) A live virus vaccine contains a weakened form of the microorganism that causes a disease such as measles and varicella vaccines.

C) An inactivated virus vaccine contains the killed version of the microorganism that causes a disease but is still capable of inducing the human body to produce antibodies, like the inactivated poliovirus vaccine.

D) A recumbent form of a vaccine is made from two or more sources and genetically alters an organism to be used in a vaccine. An example of this is the hepatitis B vaccine.

Page Ref: 506

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 8.1. Analyze the physiology of immunity in the body.

MNL LO: Analyze the concept of immunity and its application to nursing care.

6) The nurse is providing care to a client with a compromised immune system. Which independent nursing intervention should the nurse include in the client's plan of care?

A) Educating the client on the importance of a nutritious diet
B) Administering corticosteroids per order
C) Prescribing prophylactic antibiotic therapy
D) Recommending gene transfer therapy

Answer: A

Explanation: A) Although all of these interventions may be appropriate for a client with a compromised immune system, the only independent nursing intervention is educating the client on the importance of a nutritious diet.

B) It is outside the scope of nursing practice to prescribe medication and to recommend therapies.

C) It is outside the scope of nursing practice to prescribe medication and to recommend therapies.

D) It is outside the scope of nursing practice to prescribe medication and to recommend therapies.

Page Ref: 512

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 8.6. Analyze independent interventions nurses can implement for patients with alterations in immunity.

MNL LO: Analyze the concept of immunity and its application to nursing care.

7) The nurse is caring for a client with leukocytosis. Which action by the nurse is most appropriate?
A) Instructing the client on the use of an electric razor and soft toothbrush
B) Evaluating the client for bleeding and bruising
C) Assessing the client for the source of infection
D) Placing the client in reverse isolation
Answer: C
Explanation: A) Providing instruction on the use of an electric razor and soft toothbrush would be appropriate actions for a client with thrombocytopenia, or decreased platelet levels.
B) Evaluating for bleeding and bruising would be appropriate actions for a client with thrombocytopenia, or decreased platelet levels.
C) A client with leukocytosis has a white blood cell (WBC) count that is elevated above normal (>10,000 mm^3), which is an indication of infection. The appropriate action by the nurse is to assess the client for the source of infection.
D) Reverse isolation would be appropriate for a client with neutropenia, or a decrease in the number of neutrophils.
Page Ref: 490
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 8.1. Analyze the physiology of immunity in the body.
MNL LO: Analyze the concept of immunity and its application to nursing care.

8) An adolescent client is having a routine health assessment. Which immunizations should the nurse anticipate administering to the client during this visit? **Select all that apply.**
A) Herpes zoster vaccine
B) Papillomavirus vaccine
C) Rotavirus vaccine
D) Meningococcal vaccine
E) Hepatitis B vaccine
Answer: B, D
Explanation: A) The herpes zoster vaccine is typically given to older adults.
B) The papillomavirus vaccine is administered during adolescence.
C) The rotavirus vaccine is usually administered to infants.
D) The meningococcal vaccine is administered during adolescence.
E) The hepatitis B vaccine is usually administered to infants.
Page Ref: 508
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 8.1. Analyze the physiology of immunity in the body.
MNL LO: Analyze the concept of immunity and its application to nursing care.

9) The parents of a toddler are concerned because the child experiences frequent infections. Which response should the nurse make?

A) Cell-mediated immunity doesn't achieve full function until a child is roughly 5 years old.

B) The thymus doesn't begin to function until adolescence, so prior to this time, children don't produce enough T cells to adequately protect them from infectious agents.

C) Children don't develop all of the immunoglobulins they need to protect against infection until they are about 6 or 7 years of age.

D) Young children have comparatively small lymphoid tissues, which means they are less able to fight infection than are older children.

Answer: C

Explanation: A) Cell-mediated immunity achieves full function early in life.

B) The thymus begins producing T cells during the fetal period.

C) Children do not develop adequate levels of certain immunoglobulins (namely, IgA, IgE, and IgG) until they are 6 or 7 years old, so prior to this time, they are at increased risk of infection.

D) Young children have lymphoid tissues that are quite large in comparison to the rest of their bodies.

Page Ref: 514

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 8.8. Differentiate considerations related to the assessment and care of patients with alterations in immunity throughout the lifespan.

MNL LO: Analyze the concept of immunity and its application to nursing care.

10) The nurse is creating a teaching tool about the immune system. Which cells would the nurse classify as granulocytes?
A) Helper T cells
B) Macrophages
C) Natural killer (NK) cells
D) Eosinophils
Answer: D
Explanation: A) Helper T cells are both lymphocytes, not granulocytes.
B) Macrophages are mature monocytes and would not be classified as granulocytes.
C) NK cells are both lymphocytes, not granulocytes.
D) There are three types of granulocytes: neutrophils, eosinophils, and basophils.
Page Ref: 491
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 8.1. Analyze the physiology of immunity in the body.
MNL LO: Analyze the concept of immunity and its application to nursing care.

11) Three weeks after receiving a donor liver, a client begins to experience fever, tachycardia, right upper quadrant pain, and increased accumulation of fluid in the abdomen. Which condition will the nurse expect the client is experiencing when the transplanted liver becomes dangerously enlarged?
A) Hyperacute rejection
B) Chronic rejection
C) Acute rejection
D) Delayed rejection
Answer: C
Explanation: A) Hyperacute rejection occurs within minutes or hours of transplantation and is characterized by organ swelling, clot formation, and hemorrhage.
B) Chronic rejection occurs months after transplantation and involves slow, insidious organ failure.
C) Acute rejection occurs in the weeks following transplantation and is marked by pain, swelling, and enlargement of the transplanted organ.
D) Delayed is not a type of organ rejection.
Page Ref: 502
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 8.2. Differentiate alterations in immunity.
MNL LO: Analyze the concept of immunity and its application to nursing care.

12) The nurse is preparing a teaching tool about the lymphoid organs. Which organ will the nurse identify as the largest lymphoid organ in the body?
A) Thymus gland
B) Bone marrow
C) Tonsils
D) Spleen
Answer: D
Explanation: A) The thymus gland is a lymphoid organ; however, it is not the largest.
B) Bone marrow is not an organ, but rather a tissue with several lymphoid functions.
C) The tonsils are lymphoid organs; however, they are not the largest.
D) The spleen is the largest lymphoid organ in the body.
Page Ref: 498
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 8.1. Analyze the physiology of immunity in the body.
MNL LO: Analyze the concept of immunity and its application to nursing care.

13) The nurse is reviewing the different types of transfusion reactions before providing a client with packed red blood cells. As which type of hypersensitivity reaction should the nurse categorize transfusion reactions and Rh incompatibility?
A) Type I
B) Type II
C) Type III
D) Type IV
Answer: B
Explanation: A) Type I, or immediate hypersensitivity, reactions are characterized by rapid development of symptoms after exposure to an antigen; an example is anaphylaxis.
B) Type II, or cytotoxic hypersensitivity, reactions involve the rupture of cells targeted by the immune response that may affect a variety of organs and tissues; examples include transfusion reactions and Rh incompatibility.
C) Type III, or immune-complex, reactions include inflammatory response in the targeted tissues that leads to tissue damage; examples include autoimmune disorders such as systemic lupus erythematosus (SLE) and rheumatoid arthritis (RA).
D) Type IV, or delayed-type hypersensitivity, reactions involve a major histocompatibility complex and are characterized by tissue damage at the site of antigen contact within 24-48 hours of exposure; an example is allergic contact dermatitis.
Page Ref: 502
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 8.1. Analyze the physiology of immunity in the body.
MNL LO: Analyze the concept of immunity and its application to nursing care.

14) A new mother asks why breastfeeding will help prevent the baby from developing infections. Which response should the nurse make?

A) The infant receives maternal antibodies via breastmilk, and these antibodies stimulate the infant's immune system to begin producing antibodies of its own.

B) Consumption of breastmilk introduces certain antigens into the infant's body, thereby stimulating the infant's immune system to begin producing antibodies to these antigens.

C) The infant receives maternal antibodies via breastmilk, and these antibodies provide the infant with immediate protection against specific antigens.

D) Consumption of breastmilk reduces the need for vaccinations as the mother's immunity is transferred to the infant.

Answer: C

Explanation: A) Breast milk does not stimulate the infant's immune system to produce antibodies.

B) Breast milk does not introduce antigens into the infant or stimulate the immune system to produce antibodies to the antigens.

C) Passive immunity occurs when individuals receive antibodies from another person rather than by producing them through their own immune system. This type of immunity is immediate, and it can be acquired through the passing of antibodies between mother and newborn via breastmilk.

D) Breast milk does not transfer the mother's immunity to the infant.

Page Ref: 514

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 8.1. Analyze the physiology of immunity in the body.

MNL LO: Analyze the concept of immunity and its application to nursing care.

15) A client is diagnosed with leukopenia. Which condition should the nurse suspect the client is experiencing?
A) Immunocompetence
B) An infection somewhere in the body
C) Suppressed bone marrow activity
D) An abnormally high number of circulating leukocytes
Answer: C
Explanation: A) Low leukocyte levels disrupt the body's ability to adequately respond to infection and may result in immunodeficiency, not immunocompetence.
B) In individuals with proper immune system function, the presence of infection should cause an elevation in circulating leukocytes (leukocytosis) rather than leukopenia.
C) Leukopenia involves a decrease in the number of circulating leukocytes in the body. Because leukocytes are produced in the bone marrow, the presence of leukopenia suggests that an individual may have suppressed bone marrow activity.
D) In individuals with proper immune system function, the presence of infection should cause an elevation in circulating leukocytes (leukocytosis) rather than leukopenia.
Page Ref: 490
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 8.1. Analyze the physiology of immunity in the body.
MNL LO: Analyze the concept of immunity and its application to nursing care.

Exemplar 8.A HIV and AIDS

1) Once inside the body, human immunodeficiency virus (HIV) infects and destroys several types of cells, including helper T cells. List each of the events in this process in the order in which they occur.
A) Virus recognizes and invades cells that have the CD4 antigen
B) Viral RNA is acted upon by reverse transcriptase
C) Viral DNA integrates with helper T cell DNA
D) Virus disrupts cell membrane of helper T cell, leading to its destruction
E) Virus sheds its protein coat
Answer: A, E, B, C, D
Explanation: The HIV virus first recognizes and invades the cells that have the CD4 antigen. helper T cell. Once inside the cell, the virus sheds its protein coat and uses reverse transcriptase to convert the viral RNA to DNA. This viral DNA is then integrated into the host cell's DNA and duplicated during normal processes of cell division. Finally, the virus buds from the cell surface, disrupting its cell membrane and leading to destruction of the host cell.
Page Ref: 516
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 8.A.1. Analyze HIV/AIDS as it relates to immunity. Describe the pathophysiology of HIV/AIDS.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with HIV and AIDS.

2) A client with acquired immunodeficiency syndrome (AIDS) who is on antiretroviral therapy reports nausea, fever, severe diarrhea, and anorexia. Which prescribed medications does the nurse anticipate in order to relieve the anorexia and stimulate the client's appetite? **Select all that apply.**
A) Dronabinol (Marinol)
B) Zidovudine (Retrovir, AZT)
C) Abacavir (Ziagen)
D) Ciprofloxacin (Cipro)
E) Megestrol (Megace)
Answer: A, E
Explanation: A) Dronabinol (Marinol) can be prescribed to increase client appetite and promote weight gain.
B) Zidovudine (Retrovir, AZT) is an antiretroviral agent.
C) Abacavir (Ziagen) is a potent inhibitor of reverse transcriptase.
D) Ciprofloxacin (Cipro) is an anti-infective medication.
E) Megestrol (Megace) can be prescribed to increase client appetite and promote weight gain.
Page Ref: 528
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.3 Demonstrate clinical judgment founded on a broad knowledge base. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 8.A.4. Analyze HIV/AIDS as it relates to immunity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with HIV/AIDS.

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MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with HIV and AIDS.

3) The nurse is preparing a teaching tool about the human immunodeficiency virus (HIV). Which statement should the nurse delete from the tool?
A) Clients who will require blood transfusions during surgery should encourage their family members to donate the blood they will receive.
B) The only totally safe sex practices are abstinence; long-term, mutually monogamous sexual relations between uninfected individuals; and mutual masturbation without direct contact.
C) When possible, autologous transfusion is a good risk reduction strategy for clients who are undergoing surgery.
D) Clients should use condoms during every sexual encounter involving vaginal, oral, or anal intercourse.
Answer: A
Explanation: A) Autologous blood transfusions are another appropriate prevention strategy for clients who are scheduled for surgery; however, clients should be cautioned against seeking blood donations from family members, as these individuals may be reluctant to disclose whether they have engaged in any high-risk behaviors.
B) Clients can reduce their risk of contracting HIV by remaining abstinent; engaging only in long-term, mutually monogamous sexual relations between uninfected individuals; or engaging in mutual masturbation without direct contact.
C) Autologous blood transfusions are another appropriate prevention strategy for clients who are scheduled for surgery.
D) If clients opt to engage in sexual activity beyond these categories, they should use condoms during every encounter, no matter whether it involves vaginal, oral, or anal intercourse.
Page Ref: 518
Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.A.2. Analyze HIV/AIDS as it relates to immunity. Compare the risk factors and prevention of HIV/AIDS.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with HIV and AIDS.

4) The nurse is assessing a client with AIDs. Which is the most commonly observed opportunistic infection for which the nurse should assess this client?

A) Tuberculosis

B) *Pneumocystis jiroveci* pneumonia

C) *Candida albicans* infection

D) *Mycobacterium avium* complex

Answer: B

Explanation: A) Tuberculosis is also an opportunistic infection that frequently affects individuals with AIDS, but it is not as common as *Pneumocystis jiroveci* pneumonia.

B) *Pneumocystis jiroveci* pneumonia is the most common opportunistic infection affecting clients with AIDS and is a common cause of death in these clients.

C) *Candida albicans* infection is an opportunistic infection that frequently affects individuals with AIDS, but it is not as common as *Pneumocystis jiroveci* pneumonia.

D) *Mycobacterium avium* complex is also an opportunistic infection that frequently affects individuals with AIDS, but it is not as common as *Pneumocystis jiroveci* pneumonia.

Page Ref: 520

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 8.A.3. Analyze HIV/AIDS as it relates to immunity. Identify the clinical manifestations of HIV/AIDS.

MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with HIV and AIDS.

5) A client recently diagnosed with human immunodeficiency virus (HIV) states, "I don't plan on giving up sex just because I am HIV positive." Based on this data, which problem is the priority for this client?

A) Risk for Infection
B) Anxiety
C) Compromised sexuality
D) Inadequate coping skills

Answer: C

Explanation: A) The client's intention to continue having sex does not increase the risk for infection.

B) The client's intention to continue having sex does not indicate anxiety.

C) The diagnosis of HIV infection can significantly alter the patient's expressions of sexuality. Discuss safer sex practices, including hugging, cuddling, nonsexual contact, use of latex condoms and spermicidal lubricant, and mutual masturbation. Alternative forms of sexual activity and expressing affection can allow the patient and significant other to remain close.

D) The client's intention to continue having sex does not indicate inadequate coping skills.

Page Ref: 537

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 8.A.5. Analyze HIV/AIDS as it relates to immunity. Apply the nursing process in providing culturally competent care to an individual with HIV/AIDS.

MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with HIV and AIDS.

6) The nurse instructs a client with human immunodeficiency virus (HIV) infection on ways to prevent intimate partners from getting the virus. Which statement indicates to the nurse that additional teaching is needed?

A) "I know to use an oil-based lubricant to prevent spread of the virus to my partner."

B) "I can still hug my partner to show affection."

C) "I will not share my razor with my partner."

D) "I know I have to practice safer sex with my partner by using a latex condom."

Answer: A

Explanation: A) The client statement regarding use of an oil-based lubricant indicates the need for further education. Clients should use only water-based lubricants, because oil-based lubricants can result in condom damage.

B) Nonsexual contact is a safe sexual practice.

C) Any device that could transfer blood should not be shared.

D) Latex condoms can prevent the spread of HIV.

Page Ref: 537

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 8.A.5. Analyze HIV/AIDS as it relates to immunity. Apply the nursing process in providing culturally competent care to an individual with HIV/AIDS.

MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with HIV and AIDS.

7) The nurse is planning care for a pediatric client with human immunodeficiency virus (HIV). Which interventions will the nurse include to reduce the client's risk for infection? **Select all that apply.**

A) Administering tuberculosis skin tests every 6 months
B) Teaching proper food-handling techniques to the family
C) Instructing on the importance of delaying vaccinations until adulthood
D) Assessing the health status of all visitors
E) Monitoring hand-washing techniques used by the family
Answer: B, D, E
Explanation: A) Tuberculosis skin tests should be administered annually, not every 6 months.
B) Proper food handling will reduce the risk of the client being exposed to a gastrointestinal infection.
C) Pediatric clients with HIV should be immunized as soon as they reach the age recommended for diphtheria, tetanus, and acellular pertussis; inactivated poliovirus; *Haemophilus influenzae* type b; hepatitis B; pneumococcal vaccine; and annual influenza vaccine.
D) It is important to keep individuals who have symptoms of illness away from the child.
E) Handwashing helps prevent the spread and transmission of infections.
Page Ref: 535
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 8.A.6. Analyze HIV/AIDS as it relates to immunity. Differentiate care of patients with HIV/AIDS across the lifespan.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with HIV and AIDS.

8) The nurse is reviewing the laboratory results of a client who is newly diagnosed with acquired immunodeficiency syndrome (AIDS). Which result should be reported to the client's healthcare provider?

A) CD4 cell count of 195/mm^3

B) Viral load 6500 copies/mL

C) Negative tuberculin skin test

D) WBC count of 6500/mm^3

Answer: A

Explanation: A) A CD4 cell count of less than 200/mm^3 should be reported to the healthcare provider because it indicates that opportunistic infections and cancer are likely.

B) A viral load of 5000-10,000 copies/mL in a client who is known to have AIDS does not indicate the need for changes in the treatment regimen.

C) A negative tuberculin test is considered normal.

D) A WBC count of 6500/mm^3 is considered normal.

Page Ref: 520

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 8.A.4. Analyze HIV/AIDS as it relates to immunity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with HIV/AIDS.

MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with HIV and AIDS.

9) The home health nurse is visiting several clients who are diagnosed with acquired immunodeficiency syndrome (AIDS). Which client would the nurse see first?

A) A client who is receiving lamivudine (Triumeq) because of a low CD4 cell count

B) A client with *Pneumocystis jiroveci* pneumonia who called the office this morning to report a new onset of fever, cough, and shortness of breath

C) A client with wasting syndrome who needs dietary modifications and education regarding these changes

D) A client who is receiving IV antibiotics daily for toxoplasmosis

Answer: B

Explanation: A) This client is receiving treatment and does not need to be urgently assessed.

B) Based on the ABCs (airway, breathing, and circulation) and the report of new onset of fever and shortness of breath, the nurse should visit the client with *Pneumocystis jiroveci* pneumonia first to obtain vital signs and perform a respiratory assessment.

C) The client with wasting syndrome can receive teaching at any time.

D) The client is receiving treatment and can be assessed later.

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Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 8.A.5. Analyze HIV/AIDS as it relates to immunity. Apply the nursing process in providing culturally competent care to an individual with HIV/AIDS.

MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with HIV and AIDS.

10) A pregnant client with HIV is concerned about how the diagnosis might affect the health of the child. Which statement should the nurse include when teaching the client?

A) "One way to reduce the risk of transmitting the virus to your child is to opt for vaginal birth rather than cesarean delivery."

B) "Although infants can acquire HIV from their mothers at birth, the virus cannot cross the placenta during pregnancy."

C) "Most HIV medications are safe during pregnancy and taking them can reduce the risk of transmitting the virus to the fetus."

D) "Women with HIV are no more likely than uninfected women to experience miscarriage or fetal loss."

Answer: C

Explanation: A) Cesarean delivery carries a lower risk of transmission than vaginal delivery.

B) Virus transmission is possible both across the placenta and at birth.

C) Women with HIV should be advised that most HIV medications are safe during pregnancy and taking them can reduce the risk of maternal-fetal transmission.

D) Pregnant clients with HIV should be educated about the increased risk of fetal loss and neonatal mortality associated with their diagnosis.

Page Ref: 531

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

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Learning Outcome: 8.A.6. Analyze HIV/AIDS as it relates to immunity. Differentiate care of patients with HIV/AIDS across the lifespan.

MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with HIV and AIDS.

11) The nurse is caring for a client with acquired immunodeficiency syndrome (AIDS). Which type of precaution should the nurse implement for this client?
A) Droplet
B) Reverse
C) Standard
D) Contact
Answer: C
Explanation: A) Droplet precautions are not required.
B) Reverse precautions are not required.
C) Healthcare workers can prevent most exposures to HIV by using standard precautions. With standard precautions, healthcare workers treat all high-risk body fluids as if they are infectious, and use barrier precautions to prevent skin, mucous membrane, or percutaneous exposure to these fluids.
D) Contact precautions are not required.
Page Ref: 518
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 8.A.2. Analyze HIV/AIDS as it relates to immunity. Compare the risk factors and prevention of HIV/AIDS.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with HIV and AIDS.

12) A pediatric client with human immunodeficiency virus (HIV) is severely symptomatic with the additional diagnoses of lymphoma and wasting syndrome. Which clinical stage of HIV does the nurse anticipate for this client?
A) Category N
B) Category C
C) Category A
D) Category B
Answer: B
Explanation: A) Category N is non-symptomatic.
B) The client described is Category C, a severely symptomatic client with lymphoma and wasting syndrome.
C) Category A is mildly symptomatic.
D) Category B is moderately symptomatic.
Page Ref: 533
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 8.A.6. Analyze HIV/AIDS as it relates to immunity. Differentiate care of patients with HIV/AIDS across the lifespan.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with HIV and AIDS.

Exemplar 8.B Hypersensitivity

1) A pediatric client is receiving an infusion of intravenous antibiotic at the ambulatory clinic. Which clinical manifestation indicates that the client is experiencing a type I hypersensitivity reaction?
A) Erythema
B) Fever
C) Joint pain
D) Hypotension
Answer: D
Explanation: A) Erythema is associated with type IV hypersensitivity reaction.
B) Fever is associated with type III hypersensitivity reaction.
C) Joint pain is associated with type III hypersensitivity reaction.
D) Clinical manifestations associated with a type I hypersensitivity reaction include hypotension, wheezing, gastrointestinal or uterine spasm, stridor, and urticaria.
Page Ref: 541
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 8.B.3. Analyze hypersensitivity as it relates to immunity. Identify the clinical manifestations of hypersensitivity.

MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with hypersensitivity.

2) The nurse is assessing a client who is receiving IV antibiotics. Which item in the client's health history increases the risk for experiencing a hypersensitivity reaction?
A) 26 years of age
B) Caucasian race
C) Previous antibiotic therapy
D) Concurrent chronic illness
Answer: C
Explanation: A) Anyone can have a hypersensitivity reaction. However, older age increases the risk.
B) Race is not a risk factor for a hypersensitivity reaction.
C) Anyone can have a hypersensitivity reaction. However, risk generally increases with previous exposure, because antigens must be formed with the first exposure before hypersensitivity is likely to occur.
D) Concurrent chronic illness is not identified as a risk factor for a hypersensitivity reaction.
Page Ref: 545
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 8.B.2. Analyze hypersensitivity as it relates to immunity. Compare the risk factors and prevention of hypersensitivity.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with hypersensitivity.

3) A pediatric client has a ventriculoperitoneal (VP) shunt placed at birth after a meningocele repair. Which product should the nurse avoid when providing care to this client?
A) Synthetic rubber gloves
B) Polyethylene gloves
C) Non-powdered nitrile gloves
D) Latex gloves
Answer: D
Explanation: A) Synthetic rubber gloves would be safe to use with this client.
B) Polyethylene gloves would be safe to use with this client.
C) Non-powdered nitrile gloves would be safe to use with this client.
D) Meningocele is a form of spina bifida, and clients with a history of spina bifida are at increased risk for latex allergy.
Page Ref: 544
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.B.2. Analyze hypersensitivity as it relates to immunity. Compare the risk factors and prevention of hypersensitivity.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with hypersensitivity.

4) The nurse identifies that a client with allergies is at risk for shock. Which information caused the nurse to identify this problem?
A) Anaphylactic reaction to shellfish
B) A drug reaction to penicillin causing a rash
C) Glomerulonephritis
D) Dermatitis resulting from a response to laundry detergent
Answer: A
Explanation: A) Type I hypersensitivities, such as anaphylactic reactions, occur immediately and may be life-threatening. Because the client has a history of this type of reaction, a risk for shock is a potential problem.
B) A drug reaction to penicillin that causes a rash does not increase the client's risk for shock.
C) A history of glomerulonephritis does not increase the client's risk for shock.
D) Dermatitis from a laundry detergent does not increase the client's risk for shock.
Page Ref: 559
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Diagnosis
Learning Outcome: 8.B.2. Analyze hypersensitivity as it relates to immunity. Compare the risk factors and prevention of hypersensitivity.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with hypersensitivity.

5) The nurse is preparing to assess a client when one of the client's family members begins showing symptoms of latex sensitivity. Which action by the nurse is the most appropriate?
A) Ask the family member to leave the unit.
B) Transfer the client to a department that does not use latex products.
C) Wait until Monday to report the problem to the unit supervisor.
D) Obtain latex-free products for the client's room.
Answer: D
Explanation: A) Asking the family member to leave would be a violation of the client's rights.
B) Transferring the client to a department that does not use latex products is unrealistic because the family member might experience exposure on another unit. (No hospital unit can be completely latex-free.)
C) Waiting until Monday does not solve the problem.
D) When symptoms of sensitivity to latex occur on exposure, latex-free products should be supplied.
Page Ref: 546
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.B.2. Analyze hypersensitivity as it relates to immunity. Compare the risk factors and prevention of hypersensitivity.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with hypersensitivity.

6) A client is experiencing anaphylactic shock following the administration of a medication. In which position should the nurse place the client?
A) Trendelenburg position
B) Flat, with legs slightly elevated
C) Supine position
D) High-Fowler position
Answer: D
Explanation: A) The Trendelenburg position elevates the foot of the bed and is no longer recommended for the treatment of shock, as it causes the abdominal organs to press against the diaphragm, which impedes respirations and decreases coronary artery filling.
B) Lying flat is not recommended.
C) A person in a supine position may not be able to maintain an open airway.
D) Placing the client in Fowler or high-Fowler position allows optimal lung expansion and ease of breathing.
Page Ref: 558
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.B.5. Analyze hypersensitivity as it relates to immunity. Apply the nursing process in providing culturally competent care to an individual with hypersensitivity.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with hypersensitivity.

7) A client with a history of latex allergies develops audible wheezing, pruritus, urticaria, and signs of angioedema. Which action should the nurse take?
A) Teach the client regarding use of a kit that contains treatment for allergic reactions.
B) Administer diphenhydramine (Benadryl) by mouth every 4 hours per the healthcare provider's orders.
C) Administer epinephrine 1:1000 by subcutaneous injection per the healthcare provider's orders.
D) Collect a detailed history from the client regarding the history of latex allergies.
Answer: C
Explanation: A) Although providing client teaching is important, the nurse does not have time to do these things until the client's immediate and potentially dangerous physical symptoms are addressed.
B) Diphenhydramine may also be given, but it would likely be administered by injection rather than mouth due to the need for rapid drug onset.
C) For reactions with wheezing, pruritus, urticaria, and angioedema, a subcutaneous injection of 0.3-0.5 mL of 1:1000 epinephrine is generally sufficient. The nurse should give the epinephrine first due to the nature and severity of symptoms.
D) Although collecting a detailed history is important, the nurse does not have time to do these things until the client's immediate and potentially dangerous physical symptoms are addressed.
Page Ref: 551
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.B.4. Analyze hypersensitivity as it relates to immunity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hypersensitivity.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with hypersensitivity.

8) The nurse at a summer camp learns that a child received several bee stings. Which clinical manifestations would necessitate injecting the child with epinephrine (EpiPen)? **Select all that apply.**
A) Skin that is cold and clammy to the touch
B) Skin that is warm and dry to the touch
C) Hyperverbal behavior
D) Extreme anxiety and agitation
E) Facial swelling
Answer: A, D, E
Explanation: A) General symptoms of shock that would necessitate an epinephrine injection include cold and clammy skin (which is indicative of decreased perfusion).
B) Warm and dry skin is not a clinical manifestation of shock.
C) Clients who are experiencing shock are unlikely to be hyperverbal due to respiratory symptoms that make breathing and speaking difficult.
D) General symptoms of shock that would necessitate an epinephrine injection include extreme anxiety and agitation.
E) General symptoms of shock that would necessitate an epinephrine injection include facial angioedema.
Page Ref: 559
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.B.6. Analyze hypersensitivity as it relates to immunity. Differentiate care of patients with hypersensitivity across the lifespan.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with hypersensitivity.

9) The nurse is preparing a teaching tool about food allergies. Which statement does the nurse include in this tool?

A) Over the past decade, the prevalence of peanut allergy has decreased in the pediatric population.

B) Many children eventually outgrow egg, milk, and soy allergies.

C) Teenagers with food allergies are at lower risk for an allergic reaction than younger clients because they are more aware of their trigger foods and how to avoid them.

D) Peanut allergies are most common in pediatric clients over 5 years of age.

Answer: B

Explanation: A) Among pediatric clients, the prevalence of peanut allergy has increased in recent years, with children under age 3 most commonly affected.

B) It is not uncommon for people to outgrow allergies to egg, milk, soy, and wheat as they age.

C) Teenagers with food allergies have the highest risk for an allergic reaction because they have a greater tendency to eat meals outside the home and are less likely to carry their medication.

D) Among pediatric clients, the prevalence of peanut allergy has increased in recent years, with children under age 3 most commonly affected.

Page Ref: 557

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 8.B.6. Analyze hypersensitivity as it relates to immunity. Differentiate care of patients with hypersensitivity across the lifespan.

MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with hypersensitivity.

10) A pediatric client with a history of anaphylactic hypersensitivity reactions will be discharged with a prescription for an EpiPen. Which statements should the nurse include in the discharge instructions for this client and family? **Select all that apply.**
A) "It is recommended that the child wear a medical alert bracelet."
B) "This medication does not come prefilled and must be measured."
C) "Keep the medication in the car at all times."
D) "Frequently check the expiration date of the medication."
E) "Keep the medication in one location that is easy to remember."
Answer: A, D
Explanation: A) The nurse should recommend that the client wear a medical alert bracelet.
B) An EpiPen is a prefilled syringe-and-needle medication system used to treat an anaphylactic reaction.
C) The medication should not be kept in the car at all times, as it needs to be stored away from high heat and direct sunlight.
D) The EpiPens' expiration dates should be checked frequently to ensure accurate strength.
E) The client should have multiple EpiPens and they should be kept in multiple areas, not one location.
Page Ref: 557, 558
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 8.B.6. Analyze hypersensitivity as it relates to immunity. Differentiate care of patients with hypersensitivity across the lifespan.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with hypersensitivity.

11) A nurse is caring for a client with seasonal hypersensitivity reactions. What teachings should the nurse provide to improve this client's comfort? **Select all that apply.**
A) Keep doors and windows open on high-allergen days to circulate air.
B) Remain indoors, if possible, on high-allergen days.
C) Maintain a clean, dust-free environment.
D) Take antihistamine and leukotriene medications as ordered.
E) Stop taking oral corticosteroids immediately once symptoms disappear.
Answer: B, C
Explanation: A) The doors and windows should be kept closed on high-allergen days.
B) A client with seasonal hypersensitivity should be educated regarding prevention and comfort measures. The nurse should instruct the client to keep doors and windows closed on high-allergen days and to remain indoors if possible.
C) The nurse should include teaching on maintaining a clean, dust-free environment.
D) Medication instruction should include information about taking antihistamine and antileukotriene medications, not leukotriene medications.
E) The client should also be instructed to taper oral corticosteroids as ordered, not to immediately stop taking them.
Page Ref: 546
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 8.B.4. Analyze hypersensitivity as it relates to immunity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hypersensitivity.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with hypersensitivity.

12) The nurse suspects that the client is experiencing a reaction to a specific antigen. Which laboratory result supports the conclusion made by the nurse?
A) Indirect Coombs test showing no agglutination
B) Patch test with a 1-inch area of erythema
C) 2% eosinophils in the WBC count
D) Rh antigen test with negative results
Answer: B
Explanation: A) An indirect Coombs test detects the presence of circulating antibodies against RBCs; no agglutination is considered a normal finding.
B) An area of erythema after a patch test indicates a positive response to a specific antigen.
C) An eosinophil count of 2% is within the normal range.
D) An Rh antigen test with a negative result indicates that the client does not carry the antigen.
Page Ref: 550
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 8.B.4. Analyze hypersensitivity as it relates to immunity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hypersensitivity.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with hypersensitivity.

13) The nurse is asked to explain the difference between type IV hypersensitivity reactions and the other types of hypersensitivity reactions. Which response will the nurse make?
A) Unlike other types of hypersensitivity reactions, type IV reactions are antibody-mediated responses and develop almost immediately.
B) Unlike other types of hypersensitivity reactions, type IV reactions are cell-mediated responses and develop almost immediately.
C) Unlike other types of hypersensitivity reactions, type IV reactions are antibody-mediated responses and take 24 hours or more to develop.
D) Unlike other types of hypersensitivity reactions, type IV reactions are cell-mediated responses and take 24 hours or more to develop.
Answer: D
Explanation: A) Type IV are cell-mediated immune responses.
B) Type IV reactions are delayed rather than immediate.
C) Type IV reactions are cell-mediated immune responses.
D) Type IV are cell-mediated immune responses and develop 24-48 hours after exposure to an antigen.
Page Ref: 543
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.B.1. Analyze hypersensitivity as it relates to immunity. Describe the pathophysiology of hypersensitivity.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with hypersensitivity.

14) A client with allergies asks why a newer medication was prescribed. Which information will the nurse include to explain why second-generation antihistamines are often preferred in the treatment of hypersensitivity reactions?
A) Second-generation antihistamines are faster acting than first-generation antihistamines.
B) Second-generation antihistamines are less likely than first-generation antihistamines to cause drowsiness.
C) Second-generation antihistamines are available over the counter, whereas first-generation antihistamines require a prescription.
D) Second-generation antihistamines can be administered either orally or parenterally, whereas first-generation antihistamines can only be given via the oral route.
Answer: B
Explanation: A) Second-generation antihistamines are not universally faster-acting than their first-generation counterparts.
B) An important difference between first- and second-generation antihistamines is that unlike the first-generation drugs, the newer second-generation drugs do not cause drowsiness.
C) Both first- and second-generation antihistamines are available by prescription and over the counter.
D) The preferred route of administration for both first- and second-generation antihistamines is oral, although diphenhydramine (a first-generation drug) and some other medications may be given parenterally.
Page Ref: 550
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.B.4. Analyze hypersensitivity as it relates to immunity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hypersensitivity.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with hypersensitivity.

Exemplar 8.C Rheumatoid Arthritis

1) The nurse is preparing a teaching tool about rheumatoid arthritis (RA). Which potential complication will the nurse delete from the tool?
A) Risk of cesarean delivery
B) Risk of pleural effusion
C) Likelihood of uveitis
D) Risk of anemia
Answer: A
Explanation: A) Pregnant women with RA are no more likely to undergo cesarean delivery than pregnant women without RA.
B) All individuals with RA are at increased risk of plural effusion.
C) All individuals with RA are at increased risk of uveitis.
D) Individuals with RA are at risk for anemia of chronic inflammation because of the inability of the bone marrow to incorporate stored iron to produce enough healthy RBCs.
Page Ref: 565
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 8.C.4. Analyze rheumatoid arthritis as it relates to immunity. Differentiate care of patients with rheumatoid arthritis across the lifespan.
W W . T E S T . W S
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with rheumatoid arthritis.

2) A client recently diagnosed with rheumatoid arthritis (RA) asks if RA always causes crippling deformities. What information should the nurse include when teaching ways to decrease the likelihood of crippling deformities? **Select all that apply.**
A) Ignore pain as a warning signal.
B) Type instead of hand-writing items if possible.
C) Use the strongest joints possible to complete most tasks.
D) Avoid stress to any current area of deformity.
E) Stop an activity immediately if it is beyond your ability to perform.
Answer: B, C, D, E
Explanation: A) Pain is a warning signal, so the client with RA should immediately stop any activity that causes pain.
B) The client with RA should never attempt to push a joint beyond its ability. Pain is a warning signal, so the client with RA should immediately stop any activity that causes pain. The client should avoid activities (like writing) that require a strong grip.
C) The client should use the strongest joints possible to complete tasks.
D) When performing tasks, the client should avoid stress in any current area of deformity to help prevent further deformities.
E) The client with RA should immediately stop any activity that causes pain.
Page Ref: 572
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.C.3. Analyze rheumatoid arthritis as it relates to immunity. Apply the nursing process in providing culturally competent care to an individual with rheumatoid arthritis.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with rheumatoid arthritis.

3) The nurse is preparing material about rheumatoid arthritis (RA) for a health fair. Which type of client will the nurse identify as most likely to be diagnosed with this condition?
A) A 31-year-old man
B) A 42-year-old woman
C) A 65-year-old woman
D) An 18-year-old man
Answer: B
Explanation: A) RA affects three times as many women as men.
B) The typical age of onset is between 30 and 50 years.
C) It is more likely to affect women between the ages of 30 and 50 years.
D) RA is more likely to affect women between the ages of 30 and 50 years.
Page Ref: 561
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 8.C.3. Analyze rheumatoid arthritis as it relates to immunity. Apply the nursing process in providing culturally competent care to an individual with rheumatoid arthritis.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with rheumatoid arthritis.

4) The nurse is planning care for a client with rheumatoid arthritis. For which client statement should the nurse plan care for the problem of fatigue?
A) "I seem to get tired early in the day and require a nap."
B) "My joints are stiffest at night before I go to sleep."
C) "I find it difficult to move after sitting too long."
D) "I take ibuprofen for the pain as needed."
Answer: A
Explanation: A) One hallmark symptom of RA is extreme fatigue. The client's statement regarding the need for a nap supports the problem of fatigue.
B) The problem of compromised physical mobility would be appropriate for the client experiencing stiff joints before going to sleep.
C) The problem of compromised physical mobility would be appropriate for the client experiencing difficulty moving after sitting too long.
D) The problem of chronic pain would be appropriate for the client taking ibuprofen for pain as needed.
Page Ref: 572
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 8.C.3. Analyze rheumatoid arthritis as it relates to immunity. Apply the nursing process in providing culturally competent care to an individual with rheumatoid arthritis.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with rheumatoid arthritis.

5) A client with rheumatoid arthritis (RA) asks for suggestions regarding exercise. Which recommendation should the nurse make?
A) Swimming
B) Jogging
C) Tennis
D) Bowling
Answer: A
Explanation: A) Swimming exercises all the extremities without putting undue stress on joints.
B) Jogging would cause joint discomfort.
C) Tennis could cause joint discomfort.
D) Bowling could cause joint discomfort.
Page Ref: 569
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.8 Promote self-care management. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 8.C.4. Analyze rheumatoid arthritis as it relates to immunity. Differentiate care of patients with rheumatoid arthritis across the lifespan.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with rheumatoid arthritis.

6) A client with rheumatoid arthritis (RA) is being seen in the outpatient clinic for a progress checkup. Which statement indicates to the nurse that the client has met a goal of treatment?
A) "I sleep for 10 hours at night."
B) "I have increased pain in my joints all the time now."
C) "I have delegated many household chores to my children and spouse."
D) "I do not perform household chores at all anymore."
Answer: C
Explanation: A) Sleeping for 10 hours at night will not alleviate the need for frequent rest periods during the day.
B) Increased joint pain would indicate that goals have not been met.
C) One technique for reducing stress on the joints is to delegate household tasks to family members.
D) The client does not need to refrain from all household chores.
Page Ref: 574
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 8.C.3. Analyze rheumatoid arthritis as it relates to immunity. Apply the nursing process in providing culturally competent care to an individual with rheumatoid arthritis.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with rheumatoid arthritis.

7) A client with rheumatoid arthritis (RA) is prescribed hydroxychloroquine. Which teaching will the nurse provide about this medication?
A) Limit your intake of high-fat foods
B) Schedule an eye examination every 6 months
C) Stop taking this medication if symptoms improve
D) Take measures to prevent contracting an infection
Answer: B
Explanation: A) There is no reason for the client to limit the intake of high-fat foods.
B) The antimalarial drug hydroxychloroquine (Plaquenil) inhibits the movement of neutrophils and eosinophils and impairs antigen—antibody reactions. Although this drug has a relatively low toxicity, it can cause pigmentary retinitis and vision loss; clients receiving this drug require a vision examination every 6 months.
C) The client should be instructed to take the medication as prescribed.
D) Hydroxychloroquine does not cause immunosuppression.
Page Ref: 569
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.C.2. Analyze rheumatoid arthritis as it relates to immunity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with rheumatoid arthritis.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with rheumatoid arthritis.

8) A client with rheumatoid arthritis (RA) reports a pain level of 3 on a scale from 0 to 10. Which nonpharmacologic interventions will the nurse suggest to enhance the client's comfort? **Select all that apply.**
A) Discourage any position changes.
B) Encourage relaxation techniques.
C) Splint the extremity.
D) Offer heat and/or cold packs.
E) Provide distraction activities.
Answer: B, C, D, E
Explanation: A) Position changes are encouraged along with supportive equipment.
B) Nonpharmacologic activities for pain relief include relaxation.
C) Splints provide joint rest and prevent contractures.
D) Nonpharmacologic activities for pain relief include the application of heat and cold.
E) Nonpharmacologic activities for pain relief include distraction.
Page Ref: 569-570
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.B.7. Initiate effective treatments to relieve pain and suffering in light of patient values, preferences and expressed needs. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.C.3. Analyze rheumatoid arthritis as it relates to immunity. Apply the nursing process in providing culturally competent care to an individual with rheumatoid arthritis.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with rheumatoid arthritis.

9) A client with rheumatoid arthritis (RA) is in the 3rd trimester of pregnancy. For which potential issue should the nurse plan care because the client is taking an aspirin a day?
A) Higher risk for preterm delivery
B) Increased need for medication
C) Acute exacerbation of symptoms
D) Continued risk for anemia
Answer: D
Explanation: A) Many pregnant clients with RA have prolonged gestations.
B) Due to remission, a decrease in medication is often necessitated.
C) Many pregnant clients with RA often experience a remission during pregnancy and relapse after delivery.
D) If salicylate therapy is continued, anemia may be present during the postpartum period as a result of blood loss.
Page Ref: 571
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 8.C.4. Analyze rheumatoid arthritis as it relates to immunity. Differentiate care of patients with rheumatoid arthritis across the lifespan.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with rheumatoid arthritis.

10) A client with rheumatoid arthritis (RA) asks how it differs from osteoarthritis (OA). Which responses will the nurse make? **Select all that apply.**

A) "The onset of RA is gradual, whereas the onset of OA may be rapid."

B) "With OA, multiple joints are symmetrically affected; RA affects one joint at a time."

C) "The affected joints in RA feel cold to the touch, whereas the affected joints in OA are warm or hot to the touch."

D) "OA is slowly progressive, whereas RA is characterized by exacerbations and remissions."

E) "With RA, pain and stiffness occur with activity; with OA, pain and stiffness are predominant upon arising."

Answer: A, D, E

Explanation: A) The onset of both RA and OA are gradual.

B) RA affects multiple joints symmetrically, but OA affects one joint at a time.

C) The affected joints in OA feel cold to the touch, whereas the affected joints in RA are warm or hot to the touch.

D) OA is slowly progressive, whereas RA has exacerbations and remissions.

E) With RA, pain and stiffness occur with activity; with OA, pain and stiffness are predominant upon arising.

Page Ref: 562

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 8.C.1. Analyze rheumatoid arthritis as it relates to immunity. Identify the clinical manifestations of rheumatoid arthritis.

MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with rheumatoid arthritis.

11) A client with rheumatoid arthritis (RA) is prescribed nonsteroidal anti-inflammatory drugs (NSAIDs). Which actions will the nurse take when caring for this client? **Select all that apply.**
A) Monitoring for signs of allergic reaction
B) Assuring the client that NSAIDs are safe for clients with cardiovascular disease
C) Encouraging the client to take NSAIDs with a small snack to help avoid GI distress
D) Monitoring for signs of renal problems
E) Inquire about the use of herbal supplements such as feverfew, garlic, ginger, or ginkgo
Answer: A, C, D, E
Explanation: A) When providing care to a client who is receiving any medication, it is important to monitor for signs of allergic reaction.
B) Because NSAIDs can cause blood pressure alterations, they may be dangerous for clients with cardiovascular disorders.
C) Taking NSAIDs with food may help reduce symptoms of GI distress that are often associated with these drugs.
D) Clients who are on NSAIDs should be monitored for signs of renal problems, because these medications are potentially nephrotoxic.
E) Clients should also avoid herbal supplements such as feverfew, garlic, ginger, and gingko, as these substances can increase the risk of bleeding associated with NSAID use.
Page Ref: 567
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.C.2. Analyze rheumatoid arthritis as it relates to immunity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with rheumatoid arthritis.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with rheumatoid arthritis.

WwW.TeSt.Ws

12) A school-age client has arthritis that affects the knees, ankles, and elbows. For which type of juvenile idiopathic arthritis (JIA) will the nurse plan care for this client?
A) Pauciarticular
B) Polyarticular
C) Systemic
D) Osteoarthritis
Answer: A
Explanation: A) Pauciarticular arthritis primarily affects the knees, ankles, and elbows.
B) Polyarticular arthritis affects many joints (five or more), particularly the small joints of the hands and fingers. It also may affect the hips, knees, feet, ankles, and neck.
C) Systemic arthritis involves high fever, polyarthritis, and rheumatoid rash, and it also affects internal organs.
D) Osteoarthritis is a separate condition, not a form of JIA.
Page Ref: 570
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 8.C.4. Analyze rheumatoid arthritis as it relates to immunity. Differentiate care of patients with rheumatoid arthritis across the lifespan.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with rheumatoid arthritis.

13) A client with rheumatoid arthritis (RA) asks why a medication for stomach acid was prescribed. Which response will the nurse make?
A) Proton pump inhibitors help reduce the unpleasant GI-related side effects of NSAIDs, which are the most common class of medications used in the treatment of RA.
B) Proton pump inhibitors can dramatically decrease both inflammation and immune reactions and appear to slow the progression of joint destruction in RA.
C) Proton pump inhibitors help reduce the body's autoimmune response, thereby limiting the effects of the autoimmune disease process that underlies RA.
D) Proton pump inhibitors help reduce the risk of retinitis and vision loss in clients who are taking antimalarial agents as part of their therapeutic regimen for RA.
Answer: A
Explanation: A) NSAIDs are among the most common dugs used in the treatment of RA, although they may produce unpleasant gastric side effects like stomach lining irritation, erosions, and bleeding ulcers. Concurrent administration of proton pump inhibitors may reduce the risk for GI bleeding due to NSAIDs.
B) Proton pump inhibitors do not affect the inflammation, immune reactions, and joint destruction associated with RA.
C) Proton pump inhibitors do not reduce the body's autoimmune response.
D) Proton pump inhibitors do not affect the risk of vision problems that accompanies use of antimalarial agents.
Page Ref: 568
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 8.C.2. Analyze rheumatoid arthritis as it relates to immunity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with rheumatoid arthritis.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with rheumatoid arthritis.

Exemplar 8.D Systemic Lupus Erythematosus

1) A client reports feeling tired and has a change in appetite during a health interview. Which condition should the nurse suspect when a butterfly rash is assessed over the client's nose and cheeks?
A) Systemic lupus erythematosus
B) Fibromyalgia
C) Lyme disease
D) Gout
Answer: A
Explanation: A) A "butterfly rash" that covers the bridge of the nose and the cheeks is a characteristic manifestation of systemic lupus erythematosus (SLE).
B) Although fibromyalgia has some of the symptoms of SLE (e.g., joint pain and/or fatigue), it does not cause a rash over the nose and cheeks.
C) Lyme disease is not associated with a butterfly rash over the nose and cheeks.
D) Gout does not cause a butterfly rash over the nose and cheeks.
Page Ref: 577
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 8.D.3. Analyze systemic lupus erythematosus (SLE) as it relates to immunity. Identify the clinical manifestations of SLE.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with systemic lupus erythematosus.

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2) A client asks if there are any conditions that can exacerbate systemic lupus erythematosus (SLE). Which response should the nurse make?
A) "Conditions that cause hypotension often worsen SLE."
B) "GI upset is often associated with SLE exacerbation."
C) "Pregnancy is often associated with a worsening of SLE."
D) "Fever is a known trigger for SLE exacerbation."
Answer: C
Explanation: A) Hypotension does not exacerbate SLE.
B) GI upset does not exacerbate SLE.
C) Pregnancy is not contraindicated for most women with SLE. However, the pregnant client requires close monitoring because acute episodes sometimes accompany pregnancy.
D) Fever does not exacerbate SLE.
Page Ref: 585
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.D.6. Analyze systemic lupus erythematosus (SLE) as it relates to immunity. Differentiate care of patients with SLE across the lifespan.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with systemic lupus erythematosus.

3) The nurse is planning information about systemic lupus erythematosus for a community fair. For which population is this information most applicable?
A) Young female children
B) Young black males
C) Older white women
D) Females of Asian descent
Answer: D
Explanation: A) SLE most often affects women of childbearing age.
B) SLE is more common among women than men.
C) SLE most often affects women of childbearing age.
D) SLE is more common in young women of Asian descent.
Page Ref: 577
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 8.D.2. Analyze systemic lupus erythematosus (SLE) as it relates to immunity. Compare the risk factors and prevention of SLE.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with systemic lupus erythematosus.

4) A client with systemic lupus erythematosus has an elevated white blood cell count. For which problem should the nurse plan care for this client?
A) Pain
B) Anxiety
C) Infection
D) Skin breakdown
Answer: C
Explanation: A) Pain does not cause the WBC count to be elevated.
B) An elevated WBC count does not cause anxiety.
C) An elevated WBC count occurs when an infection is present. The nurse should implement infection control measures.
D) An elevated WBC count does not cause skin breakdown.
Page Ref: 583
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 8.D.5. Analyze systemic lupus erythematosus (SLE) as it relates to immunity. Apply the nursing process in providing culturally competent care to an individual with SLE.

MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with systemic lupus erythematosus.

5) A client with systemic lupus erythematosus (SLE) is prescribed immunosuppressant drugs and corticosteroids. Which information will the nurse include when teaching the client about these medications? **Select all that apply.**
A) Avoid large crowds.
B) Do not get a flu shot.
C) Use contraception to prevent pregnancy.
D) Refrain from taking aspirin products.
E) Report any signs of infection to the healthcare provider.
Answer: A, C, D, E
Explanation: A) Crowds may increase exposure to infection, which is potentially dangerous for clients who are taking immunosuppressants.
B) Annual influenza vaccination is recommended, although clients with significant immunosuppression should not receive live vaccines.
C) Immunosuppressive drugs may increase the risk of birth defects, so contraception is important.
D) Aspirin products may increase the risk of bleeding, which would further impair immune function.
E) Chills, fever, sore throat, fatigue, or malaise should be reported so related infections can be treated as quickly as possible.
Page Ref: 583
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 8.D.4. Analyze systemic lupus erythematosus (SLE) as it relates to immunity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with SLE.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with systemic lupus erythematosus.

WwW.TeSt.Ws

6) A client with systemic lupus erythematosus (SLE) is concerned about scarring from skin lesions. Which teaching should the nurse provide to minimize the risk of skin infections associated with SLE? **Select all that apply.**
A) Use sunscreen with an SPF of 15 or greater.
B) Remain indoors on sunny days.
C) Avoid swimming in a pool or the ocean.
D) Avoid sun exposure between 10:00 a.m. and 3:00 p.m.
E) Use fluorescent lighting indoors.
Answer: A, D
Explanation: A) Because there is a relationship between sun exposure and infection, the client should be instructed to use sunscreen with an SPF of at least 15.
B) The client does not need to stay indoors on sunny days as long as precautions are taken.
C) The client may swim but should reapply sunscreen after swimming.
D) The client should be instructed to avoid the sun between 10:00 a.m. and 3:00 p.m.
E) When indoors, the client should try to avoid fluorescent lighting, as exacerbations of SLE have been reported following exposure.
Page Ref: 584
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 8.D.5. Analyze systemic lupus erythematosus (SLE) as it relates to immunity. Apply the nursing process in providing culturally competent care to an individual with SLE.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with systemic lupus erythematosus.

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7) The nurse is discussing care needs with a client with systemic lupus erythematosus (SLE). Which goal should the nurse recommend to the client?
A) Learn strategies to cope with death and the dying process.
B) Remain compliant with a sun protection plan.
C) Gain weight to within 10 pounds of normal for height.
D) Report pain no higher than 4 on a scale of 0 to 10.
Answer: B
Explanation: A) SLE is not fatal.
B) Clients with SLE must protect their skin against the sun to avoid exacerbations.
C) SLE does not affect body weight.
D) SLE is not painful.
Page Ref: 586
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 8.D.5. Analyze systemic lupus erythematosus (SLE) as it relates to immunity. Apply the nursing process in providing culturally competent care to an individual with SLE.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with systemic lupus erythematosus.

8) The nurse is planning care for an adolescent client with systemic lupus erythematosus (SLE). Which action indicates to the nurse that the client has implemented the plan of care?
A) Refusing to attend school
B) Refraining from attending social functions
C) Discussing skin changes with the healthcare provider
D) Discussing skin changes with a good friend
Answer: D
Explanation: A) Refusing to go to school indicates nonacceptance of the changes to body image.
B) Refusing to attend social functions indicates nonacceptance of the changes to body image.
C) Discussing changes only with healthcare personnel does not indicate the teen has adjusted to the body image changes.
D) Peer interaction is important to teens. Being able to discuss the physical changes related to SLE with a friend indicates acceptance of the change in body image.
Page Ref: 82
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 8.D.6. Analyze systemic lupus erythematosus (SLE) as it relates to immunity. Differentiate care of patients with SLE across the lifespan.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with systemic lupus erythematosus.

WWW.TPSM.US

9) A newly married female client is diagnosed with systemic lupus erythematosus (SLE). Which statement indicates to the nurse that the client understands the treatment plan?
A) "I will take birth control pills while I am taking cytotoxic medications."
B) "I do not need to contact the doctor if I develop a fever or rash."
C) "I plan to go to a concert this weekend so that I get out of the house."
D) "I can take aspirin as indicated for pain."
Answer: A
Explanation: A) Treatment for SLE may include cytotoxic drugs. Because these drugs can cause birth defects, women who take them should be advised to avoid pregnancy by using contraceptives.
B) Clients with SLE should contact their primary care provider whenever signs of infection occur, because it means their immune system is compromised.
C) Clients with SLE should also be taught to avoid crowds, because they are potential sources of infection.
D) Aspirin can cause bleeding, so it should be taken only with extreme care.
Page Ref: 585
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 8.D.5. Analyze systemic lupus erythematosus (SLE) as it relates to immunity. Apply the nursing process in providing culturally competent care to an individual with SLE.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with systemic lupus erythematosus.

10) A client with systemic lupus erythematosus (SLE) takes hydroxychloroquine (Plaquenil) as prescribed. For which adverse effect should the nurse monitor this client?
A) Pulmonary fibrosis
B) Cushingoid effects
C) Retinal toxicity
D) Renal toxicity
Answer: C
Explanation: A) Pulmonary fibrosis is a potential adverse effect of cyclophosphamide.
B) Cushingoid effects are a concern with corticosteroid therapy.
C) Hydroxychloroquine (Plaquenil) is an antimalarial drug that is also used to reduce the frequency of acute episodes of SLE. The primary concern with Plaquenil is retinal toxicity and possible irreversible blindness.
D) Renal toxicity is not the primary concern with Plaquenil.
Page Ref: 581
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 8.D.4. Analyze systemic lupus erythematosus (SLE) as it relates to immunity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with SLE.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with systemic lupus erythematosus.

11) A client with systemic lupus erythematosus (SLE) is prescribed immunosuppressive therapy. Which statements should the nurse include when teaching the client about this treatment? **Select all that apply.**

A) "Avoid large crowds and situations that increase your exposure to infection."
B) "Report any cough or difficulty breathing to the physician if you are taking cyclophosphamide."
C) "Use aspirin instead of acetaminophen if you develop a fever."
D) "Heavy menstrual bleeding may occur during therapy."
E) "Be sure to drink plenty of liquids."

Answer: A, B, E

Explanation: A) Clients who are on immunosuppressant therapy for SLE should be advised to avoid large crowds and situations that increase their exposure to infection.
B) Clients who are on immunosuppressant therapy for SLE should be advised to report difficulty breathing or a cough.
C) Aspirin should not be used, as this may increase the risk for bleeding.
D) Women may have an absence of menstruation, not heavy bleeding, during therapy.
E) Clients who are on immunosuppressant therapy for SLE should be advised to maintain adequate oral hydration.

Page Ref: 583
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 8.D.4. Analyze systemic lupus erythematosus (SLE) as it relates to immunity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with SLE.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with systemic lupus erythematosus.

WwW.TbSn.Ws

12) The nurse is assessing a client with systemic lupus erythematosus (SLE). Which manifestation will the nurse least likely assess in this client?
A) Symmetric polyarthritis
B) Excess hair growth
C) Thrombocytopenia
D) Pleural effusions
Answer: B
Explanation: A) Common manifestations of SLE include symmetric polyarthritis.
B) Alopecia (hair loss) is also associated with SLE; excess hair growth is not.
C) Common manifestations of SLE include thrombocytopenia.
D) Common manifestations of SLE include pleural effusions.
Page Ref: 577
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 8.D.3. Analyze systemic lupus erythematosus (SLE) as it relates to immunity. Identify the clinical manifestations of SLE.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with systemic lupus erythematosus.

13) A client with systemic lupus erythematosus (SLE) is scheduled for renal function testing. For which reason is kidney damage often observed in clients with systemic lupus erythematosus (SLE)?
A) SLE involves unusually high levels of circulating antigens. Because the kidneys play a critical role in filtering these antigens from the blood, they are under excess stress in clients with SLE.
B) SLE is commonly treated with nonsteroidal anti-inflammatory drugs (NSAIDs). Because these medications carry a high risk of nephrotoxicity, their use often leads to kidney damage in clients with SLE.
C) SLE involves deposition of immune complexes in the body's connective tissues. Because connective tissue makes up a significant portion of the kidneys, these organs are a frequent site of damage in SLE.
D) SLE involves unusually high levels of circulating antibodies. Because the kidneys play a critical role in filtering these antibodies from the blood, they are under excess stress in clients with SLE.
Answer: C
Explanation: A) The kidneys do not filter antigens from the blood.
B) Even though NSAIDs are commonly used in the treatment of SLE and may exert nephrotoxic effects, use of NSAIDs is not the primary reason why kidney damage is often observed in clients with SLE.
C) SLE involves deposition of antigen-antibody complexes, also known as immune complexes, in the body's connective tissues. Because connective tissue makes up a large portion of the kidneys, these organs are frequently damaged in SLE.
D) The kidneys do not filter antibodies from the blood. Also, even though NSAIDs are commonly used in the treatment of SLE and may exert nephrotoxic effects, use of NSAIDs is not the primary reason why kidney damage is often observed in clients with SLE.

Page Ref: 576
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 8.D.3. Analyze systemic lupus erythematosus (SLE) as it relates to immunity. Identify the clinical manifestations of SLE.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with systemic lupus erythematosus.

14) The nurse is caring for a client with systemic lupus erythematosus (SLE). Which hormonal change would the nurse expect to result in an exacerbation of the condition?
A) Increase in testosterone levels
B) Increase in estrogen levels
C) Increase in overall androgen levels
D) Increase in serotonin levels
Answer: B
Explanation: A) Testosterone is an androgen, so increased testosterone levels likely would not exacerbate SLE.
B) Sex hormones are thought to influence the development of SLE. In particular, increased estrogen levels are shown to enhance antibody responses and have an adverse effect in clients with SLE.
C) Reduced androgen levels are shown to enhance antibody responses and have an adverse effect in clients with SLE.
D) Serotonin is a neurotransmitter and typically not considered a hormone, and it does not play a direct role in the exacerbation of SLE.
Page Ref: 576
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 8.D.1. Analyze systemic lupus erythematosus (SLE) as it relates to immunity. Describe the etiology of SLE.
MNL LO: Demonstrate understanding of the concept of immunity in the care of a patient with systemic lupus erythematosus.

Module 9 Infection

The Concept of Infection

1) Which actions should the nurse take to help the client with bowel and bladder dysfunction reduce the risk of infection? **Select all that apply.**
A) Isolate the client using transmission-based precautions.
B) Monitor intake and output.
C) Provide hygienic care after episodes of incontinence.
D) Use standard precautions when handling linen after episodes of incontinence.
E) Limit fluid intake.
Answer: B, C, D
Explanation: A) Isolating the client using transmission-based precautions is not necessary because these precautions are meant to prevent the spread of infection from the client to others, and this client is not currently experiencing infection.
B) Monitoring intake and output is important because it can help reveal whether a client is experiencing dehydration. Dehydration may lead to urinary stasis, which increases the risk of infection. Similarly, intake and output levels can help reveal urinary retention, which also heightens the risk of infection.
C) Providing hygienic care after episodes of bowel or bladder incontinence will ensure that the skin remains intact, reducing the risk of infection.
D) Using proper biohazard precautions after episodes of incontinence will also reduce the risk of transmitting an infection.

E) Limiting fluid intake increases infection risk by putting the client at greater risk for dehydration.
Page Ref: 605, 624
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.3. Outline the relationship between infection and other concepts.
MNL LO: Analyze the concept of infection and its application to nursing care.

2) The nurse is planning an in-service on preventing infection for the staff nurses on a hospital's medical-surgical unit. Which information should be the priority teaching point for this education?
A) Raising the temperature in each client's room
B) Assessing vital signs once daily
C) Wearing a mask for client care
D) Performing hand hygiene
Answer: D
Explanation: A) Raising the temperature in a client's room would contribute to the growth of microorganisms.
B) Assessing vital signs is important but should be done more frequently than once daily.
C) Wearing a mask for all clients is not practical and is unnecessary unless a microorganism is airborne and the client is in isolation.
D) Hand hygiene is always the first and best way to stop the spread of microorganisms, which cause infections.
Page Ref: 597
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Quality & Safety: Current best practices. | Nursing Process: Planning
Learning Outcome: 9.4. Explain health promotion and infection prevention.
MNL LO: Analyze the concept of infection and its application to nursing care.

3) The nurse is assessing a client who is recovering following surgery. Which factor would increase this client's susceptibility to infection?
A) Intact mucous membranes
B) Presence of an incision
C) Dry skin
D) Active bowel sounds
Answer: B
Explanation: A) Intact mucous membranes is a factor that helps defend the body against infection.
B) This client has a surgical incision, so the body's first line of defense, the skin, is not intact.
C) Dry skin is a factor that helps defend the body against infection.
D) The presence of active bowel sounds is a factor that helps defend the body against infection.
Page Ref: 595
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.2. Differentiate alterations that occur as a result of the infectious process.
MNL LO: Analyze the concept of infection and its application to nursing care.

4) The nurse is caring for a client being discharged with an abdominal surgical wound. Which instruction is most important for the nurse to teach this client regarding wound healing?
A) "Thoroughly irrigate the wound with hydrogen peroxide once a day."
B) "Apply a lubricating lotion to the edges of the wound twice a day."
C) "Add more fruits and vegetables to your diet."
D) "Notify the healthcare provider if you notice swelling, warmth, or tenderness at the wound site."
Answer: D
Explanation: A) Irrigating with hydrogen peroxide would break down good granulating tissue, so this would not increase healing.
B) Applying lubricating lotion to the edges of a wound would impede the healing process.
C) Increasing fruits and vegetables would increase vitamin C, which helps with wound healing, but more protein would be the best choice.
D) A client being discharged with a surgical wound has to be instructed on the detection of infection, as the skin is the first line of defense. Signs such as edema, heat, and tenderness would indicate a local infection.
Page Ref: 596-597, 604-605
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 9.5. Differentiate common assessment procedures and tests used to examine the individual's infection status.
MNL LO: Analyze the concept of infection and its application to nursing care.

WwW.TeSM.Us

5) The nurse is caring for a client who is exhibiting signs of a systemic infection following surgery. Which diagnostic tests would the nurse anticipate being ordered? **Select all that apply.**
A) Serum electrolyte levels
B) Urinalysis
C) White blood cell differential
D) White blood cell count
E) Wound culture
Answer: B, C, D, E
Explanation: A) Serum electrolyte levels are not used to determine the presence of a systemic infection.
B) Urinalysis is used to assess for the presence of bacteria or blood in the urine.
C) WBC differential provides the body's response to an infection.
D) WBC count provides information that an infection is present.
E) Wound cultures are used to identify probable microorganisms.
Page Ref: 613-615
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 9.5. Differentiate common assessment procedures and tests used to examine the individual's infection status.
MNL LO: Analyze the concept of infection and its application to nursing care.

NwW.TBSM.Ws

6) The nurse is teaching a class on infection control. Which nursing measure is most appropriate in breaking a link in the chain of infection?
A) Place contaminated linens in a paper bag.
B) Use personal protective equipment (PPE).
C) Cover one's cough by placing the mouth in the hand.
D) Wear sterile gloves for client care.
Answer: B
Explanation: A) Placing linens in a paper bag would allow germs to come out through the bag, and the linen would act as a fomite, thus allowing the chain to continue.
B) PPE, according to Occupational Safety and Health Administration (OSHA) standards, has to be used whenever the situation dictates and is a nursing measure to break a link in the chain of infection.
C) Covering one's mouth when coughing prevents airborne droplets from escaping into the air for others to contract in the chain of infection. However, the cough should be covered in the elbow, not in the hand.
D) Nonsterile gloves have to be worn when providing certain aspects of client care. The gloves should be changed between clients, and hands are to be washed.
Page Ref: 603, 607, 609-610
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.A.1. Examine human factors and other basic safety design principles as well as commonly used unsafe practices (such as, work-arounds and dangerous abbreviations). | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.1. Analyze the process of infection in the body.
MNL LO: Analyze the concept of infection and its application to nursing care.

7) The nurse is teaching a child care class for mothers of young children. Which action should the nurse teach as being the most common mode of transmission of infectious disease?
A) Children who are playing board games
B) Children who are sitting together eating meals
C) Children who are playing with the same toy
D) Children who don't wash their hands after using the bathroom
Answer: D
Explanation: A) Playing with board games will not transmit infectious disease.
B) Eating together will not transmit infectious disease.
C) Microorganisms might be left on toys that children share, but this is not the most common mode of transmission of infectious diseases.
D) The fecal-oral and respiratory routes are the most common sources of transmission in children. Poor hand hygiene is a common source of transmission.
Page Ref: 625
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 9.8. Differentiate considerations related to the assessment and care of patients with infections throughout the lifespan.

MNL LO: Analyze the concept of infection and its application to nursing care.

8) A client is receiving IV antibiotics for the treatment of a *Staphylococcus aureus* infection. Which nursing interventions are appropriate when providing care to this client? **Select all that apply.**

A) Encourage adequate fluid intake.
B) Monitor for allergic reaction.
C) Assess renal and liver function.
D) Assess pain level.
E) Monitor vital signs.

Answer: A, B, C, E

Explanation: A) Nursing interventions to support antibiotic therapy include encouraging adequate fluid intake.

B) Nursing interventions to support antibiotic therapy include monitoring for manifestations of an allergic reaction.

C) Nursing interventions to support antibiotic therapy include assessing renal and hepatic function.

D) Although some clients may experience pain related to staph infection, antibiotics do not address pain, so assessment of pain levels is not related to administration of these medications.

E) Nursing interventions to support antibiotic therapy include assessing vital signs.

Page Ref: 618
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 9.7. Summarize collaborative therapies used by interprofessional teams for patients with infections.
MNL LO: Analyze the concept of infection and its application to nursing care.

9) The healthcare provider prescribes a client to have peak and trough blood levels drawn to evaluate the therapeutic effect of an IV antibiotic. At which time should the nurse schedule the blood samples to be drawn? **Select all that apply.**
A) Prior to discontinuing the antibiotic
B) A few minutes before the next scheduled dose of medication
C) During the infusion of the antibiotic
D) 30 minutes after the IV administration
E) 1 to 2 hours after the oral administration of the medication
Answer: B, D
Explanation: A) Antibiotic trough levels are not drawn prior to discontinuing the antibiotic.
B) The trough level is usually drawn a few minutes before the next scheduled dose.
C) Antibiotic trough levels are not drawn while the medication is being provided.
D) Peak levels are drawn at specific times such as 1-2 hours after oral administration, 1 hour after intramuscular administration, and 30 minutes after IV administration.
E) A peak level would occur 1 to 2 hours after an oral dose.
Page Ref: 615
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 9.5. Differentiate common assessment procedures and tests used to examine the individual's infection status.

MNL LO: Analyze the concept of infection and its application to nursing care.

10) A pregnant client tested positive for group B *Streptococcus* (GBS) during her 36-week checkup. For which intervention should the nurse prepare the client in order to prevent transmission of infection to the neonate?
A) Not breastfeeding the neonate during the first week after birth
B) Administration of antibiotics to the neonate after birth
C) Delivery by cesarean section
D) Administration of antibiotics to the client during labor
Answer: D
Explanation: A) GBS is not transmitted to the neonate through breastfeeding.
B) Antibiotics are not given to the neonate after birth.
C) A positive GBS test does not require cesarean delivery.
D) GBS can be transmitted to the newborn during delivery. Administration of antibiotics during labor and delivery can prevent this transmission, so the nurse should prepare the mother for this intervention.
Page Ref: 627
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.6. Describe how the strength and relevance of available evidence influences the choice of interventions in provision of patient-centered care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 9.8. Differentiate considerations related to the assessment and care of patients with infections throughout the lifespan.

MNL LO: Analyze the concept of infection and its application to nursing care.

11) Which type of infection is associated with the delivery of healthcare services in a facility such as a hospital or nursing home?
A) Etiologic
B) Latent
C) Healthcare-associated
D) Hospital-associated
Answer: C
Explanation: A) All infections are etiologic; they are produced by a specific organism.
B) A latent infection is an infection that is present but not active.
C) A healthcare-associated infection is an infection that is associated with the delivery of healthcare services in a facility such as a hospital or nursing home. Nurses must be diligent about hand hygiene and other safety practices to prevent healthcare-associated infections.
D) Hospital-associated is not a classification of an infection.
Page Ref: 601
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.2. Differentiate alterations that occur as a result of the infectious process.
MNL LO: Analyze the concept of infection and its application to nursing care.

12) Which agent can be used to destroy pathogens other than spores?
A) Antiseptic
B) Disinfectant
C) Sterilizing agent
D) Isolating agent
Answer: B
Explanation: A) Antiseptics only inhibit the growth of some organisms.
B) Disinfectants destroy pathogens other than spores.
C) A sterilizing agent destroys all pathogens, including spores.
D) Isolation is used to prevent the spread of infection but does not destroy any pathogens.
Page Ref: 606
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.4. Explain health promotion and infection prevention.
MNL LO: Analyze the concept of infection and its application to nursing care.

13) Which client should the nurse anticipate will have the greatest psychosocial needs?
A) A client under standard precautions
B) A client taking antibiotics
C) A client under droplet precautions
D) A client in isolation
Answer: D
Explanation: A) All clients receive standard precautions.
B) Clients taking antibiotics may have psychosocial needs, but they will not be as severe as those of the client in isolation.
C) Clients on droplet precautions may have psychosocial needs, but they will not be as severe as those of the client in isolation.
D) Clients requiring isolation precautions can develop psychosocial problems related to their separation from other people, including sensory deprivation and decreased self-esteem. The nurse will need to provide additional care for these clients to promote their psychosocial health.
Page Ref: 606
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 9.6. Analyze independent interventions nurses can implement for patients with infection.
MNL LO: Analyze the concept of infection and its application to nursing care.

14) The nurse is caring for a client with gangrene of the toe. For which collaborative intervention should the nurse anticipate preparing the client?
A) Surgery
B) Debridement
C) Myringotomy
D) Wound irrigation
Answer: A
Explanation: A) Surgical intervention is the primary collaborative treatment for gangrene.
B) Debridement is used to remove dead tissue and debris from a wound.
C) Myringotomy is used to remove infected inner ear drainage.
D) Wound irrigation is used to remove dead tissue and debris from a wound; however, it is not used for gangrenous infections.
Page Ref: 625
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 9.7. Summarize collaborative therapies used by interprofessional teams for patients with infections.
MNL LO: Analyze the concept of infection and its application to nursing care.

Exemplar 9.A Cellulitis

1) The nurse is caring for a client who is admitted with cellulitis of the foot. Which assessment findings support this diagnosis?
A) Blood urea nitrogen (BUN) and creatinine
B) Breath sounds
C) Blood cultures
D) Redness, pain, and edema at the site
Answer: D
Explanation: A) BUN and creatinine are not nursing assessments.
B) Breath sounds are not indicated at present, as the infection is in the foot.
C) Blood cultures are ordered by the physician and are not nursing assessments.
D) Classic signs of cellulitis are swelling, pain, redness, and edema at the site.
Page Ref: 639
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.A. Analyze cellulitis as it relates to infection. Identify the clinical manifestations of cellulitis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with cellulitis.

2) The nurse is teaching a group of adolescents at a local high school about skin infections. Which students should the nurse identify as being at increased risk for developing cellulitis? **Select all that apply.**

A) A student who plucks her eyebrows
B) A student with diabetes
C) A student who is a member of the golf team
D) A student who squeezes pimples
E) A student who applies moisturizer on a daily basis

Answer: A, B, D

Explanation: A) The student who plucks her eyebrows risks an infected hair follicle, which can lead to cellulitis.

B) The student with diabetes has a weakened immune system and increased risk for nerve damage and vascular changes in the extremities, which can lead to increased potential for skin injury and cellulitis.

C) Noncontact sports like golf do not pose a risk for cellulitis.

D) The student who squeezes pimples can develop a skin infection.

E) Keeping the skin well moisturized can protect against skin breakdown and thus reduce the risk for cellulitis.

Page Ref: 638, 640

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 9.A. Analyze cellulitis as it relates to infection. Compare the risk factors and prevention of cellulitis.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with cellulitis.

3) The nurse is caring for a client who is hospitalized for cellulitis of the foot. Which problems should the nurse use to plan this client's care? **Select all that apply.**
A) Social isolation because of the skin infection
B) Compromised skin integrity
C) Acute pain
D) Problems with sleeping
E) Low self-esteem
Answer: B, C
Explanation: A) There is no evidence that the client has a problem with social isolation.
B) Clients with cellulitis have a problem with compromised skin integrity.
C) Clients with cellulitis have a problem with acute pain.
D) Clients with cellulitis would not necessarily have problems with sleeping.
E) Clients with cellulitis do not necessarily have low self-esteem.
Page Ref: 640
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 9.A. Analyze cellulitis as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with cellulitis.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with cellulitis.

4) The nurse is teaching a client with cellulitis about ways to promote healing and avoid future infections. Which client statements indicate that the teaching has been effective? **Select all that apply.**
A) "I should use antibiotic soap to cleanse my wound."
B) "I must keep my wound completely dry between cleansings."
C) "I should contact the doctor if I have a temperature of 99.5°F or higher."
D) "I should avoid swimming in lakes when I have a wound."
E) "I can stop taking antibiotics when the swelling subsides."
Answer: A, D
Explanation: A) Clients with cellulitis should wash affected areas with antibacterial soap to prevent the spread of infection.
B) Wounds should be kept at a proper moisture level as instructed, because wet or moist wounds heal faster than dry wounds.
C) The healthcare provider should be contacted for a body temperature of 101°F or higher.
D) Clients should avoid swimming in lakes when wounded, as the water may be contaminated and could cause an infection.
E) Antibiotics are taken for the full course ordered, not just until the swelling subsides.
Page Ref: 641
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 9.A. Analyze cellulitis as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with cellulitis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with cellulitis.

5) A client receiving intravenous antibiotics for 3 days as treatment for cellulitis is being prepared for discharge. Which discharge order should the nurse anticipate for this client?
A) Low-sodium diet prescribed
B) Home healthcare aide for the client
C) Oral antibiotics to be continued at home
D) Orders for evaluation by physical therapy
Answer: C
Explanation: A) A low-sodium diet is not indicated for cellulitis.
B) The client may or may not need a home health aide.
C) Antibiotics should be taken for 10 days; therefore, the nurse anticipates oral antibiotics to be continued at home.
D) There is no evidence to suggest the client needs physical therapy.
Page Ref: 641
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 9.A. Analyze cellulitis as it relates to infection. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with cellulitis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with cellulitis.

6) The nurse is providing discharge instructions to a client recovering from cellulitis. Which client statement indicates that this teaching has been effective?
A) "I will monitor for signs of infection such as fever, chills, malaise, and redness or tenderness at the site."
B) "If the lesion looks healed, I will stop taking the antibiotics so that I will not develop resistance to antibiotics."
C) "If pustules develop, I will squeeze the lesion to remove the pus."
D) "Drainage from the site is an expected finding, and I should not be concerned."
Answer: A
Explanation: A) The client will need to be taught to monitor for the signs and symptoms of infection. Infection may be manifested by fever, chills, erythema, tenderness, and drainage at the site, especially if it is cloudy or serous.
B) Stopping antibiotics before the doses are complete causes resistance.
C) Pustules are never to be squeezed open, as there is risk of greater infection.
D) Changes in the color, amount, and odor from drainage are cause for concern and should be monitored. The physician must be notified if these symptoms occur.
Page Ref: 641
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 9.A. Analyze cellulitis as it relates to infection. Identify the clinical manifestations of cellulitis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with cellulitis.

7) When providing care to a client with a wound, which evidence-based interventions should the nurse anticipate carrying out? **Select all that apply.**
A) Keeping the wound dry
B) Only covering the wound if a scab forms
C) Ensuring that the wound remains moist
D) Keeping the wound covered
E) Teaching the client that proper wound management can reduce scarring
Answer: C, D, E
Explanation: A) Many people believe that wounds should be kept dry and should not be covered until a scab forms. However, this slows wound healing and leaves the wound exposed to potential pathogens if the scab comes off.
B) Many people believe that wounds should be kept dry and should not be covered until a scab forms. However, this slows wound healing and leaves the wound exposed to potential pathogens if the scab comes off.
C) Wound covering helps maintain a moist environment, decreasing the chance of infection.
D) Wound covering helps maintain a moist environment, decreasing the chance of infection.
E) Proper wound moisture management improves the cosmetic outcome.
Page Ref: 641
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 9.A. Analyze cellulitis as it relates to infection. Compare the risk factors and prevention of cellulitis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with cellulitis.

8) On which region of the body would the nurse most expect to observe erysipelas?
A) Abdomen
B) Ankles
C) Neck
D) Back
Answer: B
Explanation: A) Erysipelas, a superficial cellulitis of the skin caused by group A S*treptococcus*, usually affects the lower extremities or the face and not the abdomen.
B) Erysipelas, a superficial cellulitis of the skin caused by group A *Streptococcus*, usually affects the lower extremities or the face. The involved area is bright red and raised with well-defined borders.
C) Erysipelas, a superficial cellulitis of the skin caused by group A *Streptococcus*, usually affects the lower extremities or the face and not the neck.
D) Erysipelas, a superficial cellulitis of the skin caused by group A *Streptococcus*, usually affects the lower extremities or the face and not the back.
Page Ref: 638
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.A. Analyze cellulitis as it relates to infection. Describe the pathophysiology of cellulitis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with cellulitis.

9) The nurse is caring for a client who has been diagnosed with orbital cellulitis. Which assessment finding should the nurse anticipate?
A) Sunken eyes
B) Edema of the affected eye
C) Increased acuity of the affected eye
D) Elevated blood pressure
Answer: B
Explanation: A) Edema of the affected site is a common symptom of cellulitis. This would not cause sunken eyes.
B) Edema of the affected site is a common symptom of cellulitis. This may cause bulging eyes.
C) The client may complain of decreased vision, not increased acuity of vision.
D) Blood pressure is unrelated to orbital cellulitis.
Page Ref: 640
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.A. Analyze cellulitis as it relates to infection. Differentiate care of patients with cellulitis across the lifespan.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with cellulitis.

10) Which organism is most commonly responsible for cellulitis?
A) *Staphylococcus epidermidis*
B) *Streptococcus pneumoniae*
C) *Streptococcus viridans*
D) *Staphylococcus aureus*
Answer: D
Explanation: A) *Staphylococcus epidermidis* produces other types of infections.
B) *Streptococcus pneumonia*e produces other types of infections.
C) *Streptococcus viridans* produces other types of infections.
D) The most common causative organism of cellulitis is *Staphylococcus aureus*, followed by methicillin-resistant *Staphylococcus aureus* and then group A *Streptococcus*.
Page Ref: 638
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.A. Analyze cellulitis as it relates to infection. Describe the etiology of cellulitis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with cellulitis.

11) The nurse caring for a client with cellulitis can expect to collaborate with which other member of the healthcare team?
A) Clinical psychologist
B) Social worker
C) Wound care specialist
D) Respiratory therapist
Answer: C
Explanation: A) Clinical psychologists are typically not involved in the care of most clients with cellulitis.
B) Social workers are typically not involved in the care of most clients with cellulitis.
C) Cellulitis is an acute bacterial infection of the dermis and underlying connective tissue. It usually occurs as a complication of a wound infection; thus, a wound care specialist is often used to promote a positive wound care plan.
D) Respiratory therapists are typically not involved in the care of most clients with cellulitis.
Page Ref: 639
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: II.A.4. Recognize contributions of other individuals and groups in helping patient/family achieve health goals. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Scope of practice, roles, and responsibilities of healthcare team members, including overlaps. | Nursing Process: Implementation
Learning Outcome: 9.A. Analyze cellulitis as it relates to infection. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with cellulitis.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with cellulitis.

Exemplar 9.B Conjunctivitis

1) The nurse is assessing a college student who presents with red, swollen eyes; photophobia; and yellowish drainage from the conjunctiva. Which question should the nurse ask the client first?
A) "Have you had extra caffeine this week?"
B) "Did you get sand in your eye recently?"
C) "Have you been exposed to HIV?"
D) "Have any of your friends experienced these symptoms?"
Answer: D
Explanation: A) Exposure to caffeine is not a known cause of conjunctivitis and the question would not be appropriate to ask this client to determine the cause of the symptoms.
B) Sand in the eye is not a known cause of conjunctivitis and the question would not be appropriate to ask this client to determine the cause of the symptoms.
C) Exposure to HIV is not a known cause of conjunctivitis and the question would not be appropriate to ask this client to determine the cause of the symptoms.
D) The client is exhibiting signs and symptoms of conjunctivitis. The nurse should explore ways in which the client may have been exposed. Most cases of conjunctivitis are spread by hand to eye contact.
Page Ref: 644
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 9.B. Analyze conjunctivitis as it relates to infection. Describe the etiology of conjunctivitis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with conjunctivitis.

2) When planning care for a client with trachoma, which potential complication should the nurse consider?

A) Scarring of the cornea
B) Eye muscle weakness
C) Damaged iris
D) Retinal detachment

Answer: A

Explanation: A) Trachoma is a chronic form of conjunctivitis that causes the formation of granulation tissue that is abraded by the lashes, leading to scarring of the cornea and eventual blindness.

B) Trachoma does not cause eye muscle weakness.

C) Trachoma does not damage the iris.

D) Trachoma does not cause a detached retina.

Page Ref: 645

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 9.B. Analyze conjunctivitis as it relates to infection. Identify the clinical manifestations of conjunctivitis.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with conjunctivitis.

3) The nurse is teaching a mother how to administer optical antibiotics to her child who has conjunctivitis. Which statement made by the mother indicates teaching has been effective?
A) "I will drop the medication onto the eyeball."
B) "I will wait 10 seconds between drops."
C) "I will wash my hands before instilling the medication."
D) "I will rub the eye with a cotton ball after I administer the medication."
Answer: C
Explanation: A) Medication is dropped into the lower conjunctival sac.
B) The time between drops is 1 to 5 minutes, depending on the type of medication.
C) Teach the client to wash hands thoroughly before and after instilling eye medications. Handwashing is the single most important means of preventing transmission of infection.
D) The eyes should not be rubbed after instillation.
Page Ref: 647
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 9.B. Analyze conjunctivitis as it relates to infection. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with conjunctivitis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with conjunctivitis.

4) The nurse is providing care for a pediatric client with bacterial conjunctivitis. Which interventions should the nurse use as part of the collaborative management of the client? **Select all that apply.**

A) Recommending dark sunglasses
B) Recommending removing contacts at night
C) Contacting the client's school nurse
D) Performing careful hand hygiene
E) Administering antiviral therapy

Answer: A, C, D

Explanation: A) Dark glasses will help to reduce the photophobia that many clients with conjunctivitis experience.
B) Contacts should not be worn during conjunctivitis.
C) It is often appropriate for the nurse to contact the client's school nurse to discuss increased prevention and student education.
D) Careful hand hygiene is a standard method for managing the client with conjunctivitis.
E) Antibiotics, not antiviral medications, are prescribed with conjunctivitis.

Page Ref: 646
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.B. Analyze conjunctivitis as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with conjunctivitis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with conjunctivitis.

5) The nurse is providing discharge instructions for a client who has acute conjunctivitis from *Staphylococcus*. Which information should the nurse include when teaching this client? **Select all that apply.**
A) "It is OK to share makeup once the infection has resolved."
B) "Do not share towels, makeup, or contact lenses with anyone else, as this can spread the infection."
C) "You can soak your eyelids with a warm cloth to soften crusts and exudates that may form."
D) "Wash your hands before cleansing the eye and administering eye drops."
E) "You may rub your eyes if they are itchy."
Answer: B, C, D
Explanation: A) Sharing supplies, such as makeup is never a good idea even after the infection is cleared, due to potential for cross-contamination.
B) Sharing supplies, such as towels, make-up, or contact lenses, is never a good idea even after the infection is cleared, due to potential for cross-contamination.
C) Soaking the lids with a warm cloth will soften the crusts from exudates that accompany the *Staphylococcus* infection.
D) Handwashing (hand hygiene) will minimize the risk of bringing in other organisms to an already infected eye.
E) The action of rubbing one's eyes can traumatize the eyes further and increase the risk of cross-contamination.
Page Ref: 647-648
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.B. Analyze conjunctivitis as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with conjunctivitis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with conjunctivitis.

6) The nurse is assessing a client who presents with purulent drainage and crusting of the eye. The nurse should recognize that these findings are most consistent with which type of infection?
A) Viral conjunctivitis
B) Allergic conjunctivitis
C) Bacterial conjunctivitis
D) Fungal conjunctivitis
Answer: C
Explanation: A) The discharge from viral conjunctivitis is serous (watery).
B) Allergic conjunctivitis produces watery to thick drainage and is characterized by itching.
C) Bacterial conjunctivitis has a purulent discharge that may result in crusting.
D) Fungi do not cause conjunctivitis.
Page Ref: 644
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.B. Analyze conjunctivitis as it relates to infection. Identify the clinical manifestations of conjunctivitis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with conjunctivitis.

7) Which term is commonly used by clients to describe conjunctivitis?
A) Stye
B) Pink eye
C) Red eye
D) Retinitis
Answer: B
Explanation: A) A stye is a pimple-like infected oil gland on or near the edge of the eyelid.
B) Clients commonly refer to conjunctivitis as "pink eye."
C) Conjunctivitis is not referred to as red eye.
D) Retinitis is a disease related to the retina, not the conjunctiva of the eye. Retinitis causes vision loss, not inflammation, redness, and discharge.
Page Ref: 643
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.B. Analyze conjunctivitis as it relates to infection. Describe the pathophysiology of conjunctivitis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with conjunctivitis.

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8) A client who uses extended-wear contact lenses should be taught measures for reducing the risk of which condition?
A) Conjunctivitis
B) Cataracts
C) Glaucoma
D) Macular degeneration
Answer: A
Explanation: A) Individuals who use extended-wear contact lenses are at higher risk of developing conjunctivitis. Therefore, client teaching should include prevention of eye infections.
B) The client is not at risk for cataracts because of the contact lenses.
C) The client is not at risk for glaucoma because of the contact lenses.
D) The client is not at risk for macular degeneration because of contact lenses.
Page Ref: 648
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.B. Analyze conjunctivitis as it relates to infection. Compare the risk factors and prevention of conjunctivitis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with conjunctivitis.

9) A labor and delivery nurse is providing care for a neonate in the first few minutes after birth. Which medication will the nurse provide to promote eye health and prevent conjunctivitis in the infant?
A) Oral tetracycline
B) Erythromycin as an eye ointment
C) Ceftriaxone as an eye drop
D) Parenteral acyclovir
Answer: B
Explanation: A) Tetracycline may be used instead of erythromycin immediately after birth, but it will be used as an eye ointment, not as an oral formulation.
B) Prevention of conjunctivitis in a newborn is provided by the administration of an antibiotic eye ointment, usually erythromycin.
C) Ceftriaxone is only administered for a confirmed case of gonococcal conjunctivitis.
D) Parenteral acyclovir is only administered for a confirmed case of conjunctivitis due to herpes simplex virus.
Page Ref: 646-647
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.B. Analyze conjunctivitis as it relates to infection. Differentiate care of patients with conjunctivitis across the lifespan.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with conjunctivitis.

Exemplar 9.C Influenza

1) The nurse is caring for a client who presents with acute malaise, muscle aches, and fever. Which additional assessment findings should the nurse recognize as consistent with influenza? **Select all that apply.**

A) No history of vaccinations within the past 12 months
B) Nonproductive cough
C) Hypotension
D) Difficulty urinating
E) Dizziness
Answer: A, B
Explanation: A) Based on the presenting symptoms, the nurse would ask whether the client has had a seasonal flu shot or recently been exposed to the flu.
B) Usually, the cough of a client with influenza is nonproductive.
C) Hypotension is not a manifestation of influenza.
D) Difficulty urinating is not a manifestation of influenza.
E) Dizziness is not a manifestation of influenza.
Page Ref: 650-651
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 9.C. Analyze influenza as it relates to infection. Identify the clinical manifestations of influenza.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with influenza.

2) The nurse is working in a primary care setting. Which clients should the nurse identify as being at high risk for influenza or its complications? **Select all that apply.**
A) A 25-year-old pregnant woman at 20 weeks' gestation
B) A 65-year-old woman
C) A 3-year-old with cystic fibrosis
D) A 35-year-old man with a severe allergy to eggs
E) A 20-year-old healthcare worker
Answer: A, B, C, E
Explanation: A) People at increased risk of influenza or its complications include pregnant clients.
B) People at increased risk of influenza or its complications anyone age 50 or older.
C) Patients with chronic disorders, especially pulmonary diseases, are more susceptible as well.
D) A man with an allergy to eggs is not at increased risk for influenza or its complications.
E) Healthcare workers have increased risk of exposure to influenza.
Page Ref: 650
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.C. Analyze influenza as it relates to infection. Compare the risk factors for and prevention of influenza.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with influenza.

3) Which information should the nurse include when teaching parents of pediatric clients about ways to decrease the spread of influenza? **Select all that apply.**
A) "Cover your cough" education
B) An explanation of appropriate hand hygiene
C) Methods for safe food preparation and storage
D) Where to obtain the influenza vaccine
E) The importance of withholding immunizations for children with compromised immune systems
Answer: A, B, D
Explanation: A) Teaching children to use respiratory etiquette helps control the growth and spread of microorganisms.
B) Teaching children to wash their hands helps control the growth and spread of microorganisms.
C) Teaching parents safe food preparation and storage is another tool to prevent the spread of microorganisms, but it is not related to the flu virus.
D) The influenza vaccine can decrease each child's susceptibility to influenza infection.
E) Immunizations should not be withheld from immunocompromised children.
Page Ref: 650, 654
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 9.C. Analyze influenza as it relates to infection. Compare the risk factors for and prevention of influenza.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with influenza.

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4) Which action should the nurse take to promote effective breathing in a client with respiratory manifestations of the flu? **Select all that apply.**

A) Maintain adequate hydration.
B) Teach the client coughing and deep breathing.
C) Prepare the client for the possibility of a tracheostomy tube.
D) Keep the head of the bed elevated.
E) Administer antitussives during the day.

Answer: A, B, D

Explanation: A) Hydration thins the mucus and also aids in clearing the airway.
B) Coughing and deep breathing are essential for achieving airway clearance.
C) Insertion of a tracheostomy and oxygen are not primary treatments for ineffective airway clearance.
D) Keeping the head of the bed elevated improves lung excursion and reduces the work of breathing.
E) Antitussives should be administered at night to promote sleep but should not be administered during the day to promote airway clearance through coughing.

Page Ref: 653
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 9.C. Analyze influenza as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with influenza.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with influenza.

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5) The nurse makes a home visit to a client recovering from influenza. Which client statements indicate that desired outcomes have been met? **Select all that apply.**
A) "I'm eating healthy foods now."
B) "I went back to work."
C) "I haven't had chills since I left the hospital."
D) "I slept the whole night without coughing."
E) "I was able to take a walk today."
Answer: C, D
Explanation: A) Eating a healthy diet does not indicate that the client's flu has resolved.
B) Returning to work does not indicate that the client's flu has resolved.
C) Desired outcomes for a client recovering from the flu include absence of symptoms of acute infection (such as fever and chills).
D) Desired outcomes for a client recovering from the flu include resolution of respiratory symptoms and resumption of normal sleep-rest patterns.
E) Being able to walk does not indicate that the client's flu has resolved.
Page Ref: 654
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 9.C. Analyze influenza as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with influenza.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with influenza.

6) The nurse is reviewing diagnostic and laboratory studies performed for a client with influenza. Which result should the nurse recognize as being consistent with influenza?
A) Decreased white blood cell count
B) Increased BUN
C) Decreased sodium level
D) Fluid-filled lungs on chest x-ray
Answer: A
Explanation: A) The white blood cell count of a client with influenza will typically be decreased.
B) Laboratory tests for BUN are not usually associated with influenza.
C) Sodium levels are not usually associated with influenza.
D) Unless the client with influenza develops complications, the chest x-ray is clear.
Page Ref: 651
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.C. Analyze influenza as it relates to infection. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with influenza.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with influenza.

7) Which interventions should the nurse incorporate into the plan of care for a client diagnosed with influenza? **Select all that apply.**
A) Placing droplet and contact precaution signs on the client's room door
B) Placing the client in a negative air flow room
C) Placing a ventilator in the room
D) Notifying other departments of the diagnosis
E) Using appropriate PPE
Answer: A, E
Explanation: A) To prevent the spread of influenza, the client is placed in a private room with signs for droplet and contact precautions.
B) Negative air flow rooms are for diseases such as chickenpox, measles, and severe acute respiratory syndrome (SARS).
C) There is no indication that this client will need a ventilator.
D) Placing signs on the door is the way to notify other departments of precautions; no additional notification is needed.
E) It is important for healthcare workers to use appropriate PPE for these transmission-based precautions.
Page Ref: 654
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 9.C. Analyze influenza as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with influenza.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with influenza.

8) Necrosis of respiratory epithelial cells and shedding of serous and ciliated cells of the respiratory tract produce which common symptom of influenza?

A) Malaise
B) Coryza
C) Cough
D) Rhinorrhea

Answer: D

Explanation: A) Malaise is a general symptom of influenza and is not directly related to the shedding of cells from the respiratory tract.

B) Serous cells are replaced more rapidly than ciliated cells, leading to coryza.

C) Serous cells are replaced more rapidly than ciliated cells, leading to continued cough.

D) Shedding of serous and ciliated cells of the respiratory tract leads to rhinorrhea, or a runny nose.

Page Ref: 649

Cognitive Level: Remembering

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 9.C. Analyze influenza as it relates to infection. Describe the pathophysiology of influenza.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with influenza.

9) Because of the way the influenza virus is transmitted from person to person, which precaution should the nurse implement?
A) Droplet precautions
B) Isolation precautions
C) Airborne precautions
D) Contact precautions
Answer: A
Explanation: A) Influenza is spread through droplets when the client sneezes or coughs. Therefore, droplet precautions should be used.
B) Isolation precautions limit the number of people who come in contact with the client and are used only for severe or life-threatening infections.
C) Airborne precautions are used for tuberculosis and other infections that are airborne.
D) Contact precautions are used when the nurse is at risk of contracting infected body fluids such as stool or wound drainage.
Page Ref: 654
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.C. Analyze influenza as it relates to infection. Describe the etiology of influenza.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with influenza.

10) Which oral antiviral drug that is commonly prescribed for influenza A and B works by preventing the release of newly formed virus?

A) Rimantadine (Flumadine)
B) Zanamivir (Relenza)
C) Oseltamivir (Tamiflu)
D) Amantadine (Symmetrel)

Answer: C

Explanation: A) Rimantadine (Flumadine) is no longer recommended for the prevention or treatment of influenza because of the high incidence of resistance by the influenza virus.
B) Zanamivir (Relenza) has a similar mechanism of action, but it is given via inhalation.
C) Oseltamivir (Tamiflu) is an oral antiviral drug that is prescribed for influenza A and B. It works by preventing the release of newly formed virus.
D) Amantadine (Symmetrel) is no longer recommended for the prevention or treatment of influenza because of the high incidence of resistance by the influenza virus.

Page Ref: 623
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.C. Analyze influenza as it relates to infection. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with influenza.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with influenza.

11) Which action should the nurse recommend for a pregnant client who is concerned about a recent flu outbreak?
A) Receive the influenza vaccination.
B) Stay home until the influenza outbreak has ended.
C) Take amantadine (Symmetrel) prophylactically.
D) Eat foods that boost the immune system.
Answer: A
Explanation: A) The influenza vaccine is the client's best method of preventing influenza infection, and it has no indication of harm to the unborn child.
B) Recommending the client stay home for several weeks is not a practical method of prevention.
C) Amantadine is a Category C drug and should not be given during pregnancy to prevent influenza.
D) Although eating foods that boost the immune system is a good recommendation, it will not be as effective at preventing influenza in an exposed individual as the influenza vaccine.
Page Ref: 650, 652
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.C. Analyze influenza as it relates to infection. Differentiate care of patients with influenza across the lifespan.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with influenza.

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12) The nurse is caring for a group of clients with influenza. Which client should the nurse identify as being at greatest risk for complications?
A) A 53-year-old woman
B) A 72-year-old man
C) A 35-year-old woman
D) A 12-year-old boy
Answer: B
Explanation: A) A middle-aged client is not at the greatest risk of complications from influenza.
B) Older adults are more at risk because their immune defenses become weaker with age.
C) An adult client is not at the greatest risk of complications from influenza.
D) Children under the age of 5 are at highest risk of developing complications related to influenza infection.
Page Ref: 652
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.C. Analyze influenza as it relates to infection. Differentiate care of patients with influenza across the lifespan.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with influenza.

Exemplar 9.D Otitis Media

1) The nurse walks into an examination room and sees a young child pulling at their ear. The nurse recognizes this behavior is most characteristic of which health problem?
A) Sore throat
B) Hunger
C) Otitis media
D) Head cold
Answer: C
Explanation: A) Pulling at the ear does not indicate a sore throat.
B) Pulling at the ear does not indicate hunger.
C) Pulling at the ear is a characteristic sign of otitis media in a young child.
D) Pulling at the ear does not indicate a head cold.
Page Ref: 656
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.D. Analyze otitis media as it relates to infection. Identify the clinical manifestations of otitis media.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with otitis media.

2) The nurse is caring for a client who refuses treatment for otitis media. Which condition is this client at risk for developing?
A) External otitis
B) Meningitis
C) Pneumonia
D) Influenza
Answer: B
Explanation: A) Otitis media is not known to cause external otitis.
B) The bacterial infection from otitis media may migrate internally, leading to the development of bacterial meningitis.
C) Otitis media does not cause pneumonia.
D) Otitis media does not cause influenza.
Page Ref: 655
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.D. Analyze otitis media as it relates to infection. Compare the risk factors and prevention of otitis media.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with otitis media.

3) The nurse is teaching the mother of an infant with otitis media to manage the associated fever and pain. Which instruction by the nurse is correct?
A) Swaddle the baby in blankets.
B) Feed the baby solid foods.
C) Administer acetaminophen.
D) Bathe the baby with cool water.
Answer: C
Explanation: A) Swaddling the baby with blankets is not going to reduce the fever or help the pain.
B) The baby may not be of the age to take solid foods.
C) Acetaminophen will help reduce the child's fever and reduce the pain.
D) Bathing with cool water is not an appropriate intervention to reduce the fever of a baby.
Page Ref: 659
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 9.D. Analyze otitis media as it relates to infection. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with otitis media.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with otitis media.

4) Which instruction should the nurse provide to an adolescent client with otitis media with regard to pain?

A) Apply a cold compress to the affected ear.

B) Report abrupt relief of pain immediately.

C) Continue plans for air travel.

D) Report increased pain when moving the outer ear.

Answer: B

Explanation: A) Heat should be applied to dilate surrounding blood vessels and decrease swelling.

B) Abrupt relief of pain may mean that the tympanic membrane has perforated.

C) Drastic changes in barometric pressure can increase pain considerably, so clients are discouraged from traveling by air.

D) The pain of otitis media is not aggravated by movement of the external ear.

Page Ref: 659

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 9.D. Analyze otitis media as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with otitis media.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with otitis media.

5) The nurse correctly explains to a young mother that bottle-feeding an infant in the upright position may help to prevent which infectious health problem?
A) Choking
B) Aspiration
C) Sinus infection
D) Otitis media
Answer: D
Explanation: A) Although choking can occur due to an improper position during bottle-feeding, they are not infectious health problems.
B) Although aspiration can occur due to an improper position during bottle-feeding, they are not infectious health problems.
C) Children are not prone to sinus infection during infancy as the result of feeding position.
D) Infants and small children who are bottle-fed in a supine position have a greater probability of developing otitis media because the eustachian tube opens when the child sucks, and the horizontal angle provides easy access to the middle ear.
Page Ref: 658
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.D. Analyze otitis media as it relates to infection. Differentiate care of patients with otitis media across the lifespan.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with otitis media.

6) A client has completed the full course of antibiotics prescribed to treat otitis media. Which primary manifestation of the disorder will be relieved as evidence that treatment has been effective?
A) Impaired hearing
B) Dizziness
C) Pain
D) Nausea and vomiting
Answer: C
Explanation: A) Impaired hearing is a secondary manifestation.
B) Dizziness is a secondary manifestation.
C) Ear pain is the most common symptom of otitis media that motivates the client to seek healthcare.
D) Nausea and vomiting are secondary symptoms.
Page Ref: 656
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 9.D. Analyze otitis media as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with otitis media.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with otitis media.

7) A toddler with otitis media is prescribed amoxicillin clavulanate 250 mg/5 mL three times daily by mouth for 10 days. Which information should the nurse teach the mother about this medication?
A) "It is OK to stop the antibiotic if the child begins to have side effects."
B) "Give the antibiotic for the full 10 days as prescribed."
C) "It is important to measure the prescribed dose in a household teaspoon."
D) "Be sure to administer a loading dose of the medication when you get home."
Answer: B
Explanation: A) Stopping the antibiotic before the prescribed time will permit remaining bacteria to reproduce, and the otitis media will return, possibly with antibiotic-resistant organisms.
B) Antibiotics must be administered for the full number of days ordered to prevent mutation of resistant strains of bacteria.
C) A household teaspoon could contain less than 5 mL, and the full dose must be given.
D) A loading dose was not ordered.
Page Ref: 657
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.D. Analyze otitis media as it relates to infection. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with otitis media.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with otitis media.

8) The nurse is teaching the parents of an infant who is diagnosed with acute otitis media. Which information is the priority teaching point for these parents?
A) Administer a decongestant for nasal congestion.
B) Keep the baby in a flat position during sleep.
C) Administer acetaminophen to relieve pain and decrease fever.
D) Place the baby to sleep with a pacifier.
Answer: C
Explanation: A) Decongestants are not recommended for treatment of acute otitis media.
B) A flat position could exacerbate the discomfort.
C) Parents are taught to administer acetaminophen to relieve the discomfort and decrease fever associated with acute otitis media.
D) Placing infants to sleep with a pacifier can increase the incidence of otitis media.
Page Ref: 659
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.D. Analyze otitis media as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with otitis media.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with otitis media.

9) Which body structure provides a route by which infectious organisms can enter the middle ear to cause otitis media?
A) Nasopharynx
B) Eustachian tube
C) Tympanic membrane
D) Sinus cavity
Answer: B
Explanation: A) The nasopharynx does not directly connect to the middle ear.
B) The eustachian tube connects the middle ear with the nasopharynx, and this tube provides a route through which infectious organisms can enter the middle ear from the nose and throat.
C) The tympanic membrane separates the middle ear from the external auditory canal. It protects the middle ear from infectious organisms when it is intact.
D) The sinus cavity does not directly connect to the middle ear.
Page Ref: 655
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.D. Analyze otitis media as it relates to infection. Describe the pathophysiology of otitis media.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with otitis media.

10) Which child has a risk factor for developing otitis media?
A) A 10-year-old child who plays baseball and soccer
B) A 14-year-old child who lives on a farm
C) A 5-year-old child who stays with her grandmother during summer break
D) An 18-month-old child who attends daycare while his parents work
Answer: D
Explanation: A) A 10-year-old child is not at increased risk for otitis media.
B) A 14-year-old child is not at increased risk for otitis media.
C) A 5-year-old child is not at increased risk for otitis media.
D) Risk factors for developing otitis media include being younger than age 2, participating in group care settings, having seasonal allergies, or being exposed to poor air quality. The 18-month-old child has two risk factors for developing otitis media.
Page Ref: 655
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.D. Analyze otitis media as it relates to infection. Compare the risk factors and prevention of otitis media.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with otitis media.

Exemplar 9.E Pneumonia

1) An older adult client is admitted with pneumonia. Which manifestations would the nurse expect to find when assessing this client? **Select all that apply.**
A) Hemoptysis
B) Increased appetite
C) Cough
D) Tachypnea
E) Fever
Answer: A, C, D, E
Explanation: A) Common symptoms of pneumonia include hemoptysis.
B) Decreased appetite may accompany symptoms of pneumonia, not increased appetite.
C) Common symptoms of pneumonia include cough.
D) Common symptoms of pneumonia include tachypnea.
E) Common symptoms of pneumonia include fever.
Page Ref: 666
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.E. Analyze pneumonia as it relates to infection. Identify the clinical manifestations of pneumonia.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with pneumonia.

2) An older adult client asks the nurse what can be done to decrease the risk of developing pneumonia. Which responses by the nurse are most appropriate? **Select all that apply.**
A) "Once per day, you should eat yogurt that is supplemented with *L. casei immunitas* cultures."
B) "Eliminating habits like smoking can help."
C) "You can get the pneumonia vaccination, which may help decrease your risk in the future."
D) "Avoiding alcohol will reduce your risk."
E) "There is nothing you can do to decrease your risk of pneumonia in the future."
Answer: B, C, D
Explanation: A) *L. casei immunitas* cultures have not been proven to support immune function.
B) Smoking increases the risk of pneumonia. Smoking injures tissues in the airways and decreases the action of the cilia.
C) Pneumonia vaccines can also decrease the risk of developing the disease in the future.
D) Alcohol consumption increases the risk of pneumonia. Alcohol interferes with the actions of macrophages.
E) Telling the client that it is not possible to decrease the risk of pneumonia is incorrect.
Page Ref: 665
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.E. Analyze pneumonia as it relates to infection. Compare the risk factors and prevention of pneumonia.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with pneumonia.

3) The nurse is caring for an older adult client who is hospitalized with a second episode of pneumonia in the past 18 months. The client has expressed frustration to the nurse and states, "I never got sick when I was younger. Why is this happening?" Which response by the nurse is most appropriate?

A) "As you grow older, your immune system just quits working."

B) "As you grow older, there is a decrease in the immune response, which puts you at greater risk for developing an infection."

C) "As you grow older, there is an overall increase in the speed and strength of your immune response."

D) "As you grow older, there is an increase in the number of B cells in circulation, which hinders the immune response."

Answer: B

Explanation: A) The immune system does not quit working totally.

B) As a person grows older, there is an overall decrease in the speed and strength of the immune response.

C) As a person grows older, there is an overall decrease in the speed and strength of the immune response.

D) There is a decrease in the number of B cells in circulation.

Page Ref: 665

Cognitive Level: Applying

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 9.E. Analyze pneumonia as it relates to infection. Differentiate care of patients with pneumonia across the lifespan.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with pneumonia.

4) The nurse is caring for a client with pneumonia. Which intervention should the nurse include in this client's plan of care to promote effective airway clearance?
A) Perform chest percussion every 4 hours and prn.
B) Administer the pneumococcal vaccine prior to discharge.
C) Limit fluid intake to 1000 mL per day.
D) Instruct the client to reduce the amount of smoking.
Answer: A
Explanation: A) Chest percussion can help clear secretions.
B) The pneumococcal vaccine would prevent the condition, not improve airway clearance.
C) Patients with pneumonia are encouraged to increase fluid intake.
D) The client should be provided with education on smoking cessation as this helps with airway clearance in the client with pneumonia.
Page Ref: 672
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 9.E. Analyze pneumonia as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with pneumonia.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with pneumonia.

5) The nurse is providing discharge teaching to a client recovering from pneumonia. Which client statement indicates that additional teaching is needed?
A) "I can't get the influenza vaccine due to my allergy to eggs."
B) "I will get the influenza vaccine every year."
C) "I will get the pneumococcal vaccine every fall."
D) "The pneumococcal vaccine protects against bacterial pneumonia."
Answer: C
Explanation: A) Influenza vaccine should not be given to those with an allergy to eggs.
B) Influenza vaccine is administered annually to healthy individuals.
C) The pneumococcal vaccine is administered once. Revaccination is only recommended in persons with renal failure, those who have had splenectomies, those with malignancies, and those with HIV/AIDS.
D) Because the pneumococcal vaccine is made of antigens from 23 types of pneumococci, a type of bacteria, it only protects against bacterial pneumonias.
Page Ref: 665-666
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 9.E. Analyze pneumonia as it relates to infection. Compare the risk factors and prevention of pneumonia.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with pneumonia.

6) Which intervention should the nurse carry out to manage fever in a client with pneumonia? **Select all that apply.**
A) Increase the temperature of the room environment to prevent shivering.
B) Administer antipyretic medications.
C) Restrict fluids during periods of hyperthermia because of the risk of electrolyte imbalance.
D) Use ice packs and a tepid bath every 2 hours.
E) Promote frequent rest periods to increase energy reserve.
Answer: B, E
Explanation: A) Increasing the room temperature would cause the client discomfort.
B) The nurse should administer antipyretic medications as indicated for elevated temperatures.
C) The nurse should encourage fluid intake rather than restrict fluids because of the risk of electrolyte imbalance.
D) The nurse should use ice packs, cool/tepid baths, or a hypothermia blanket with caution and only as needed.
E) The nurse should enforce frequent rest periods because rest increases energy reserve that is depleted by increased metabolic, heart, and respiratory rates.
Page Ref: 667
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 9.E. Analyze pneumonia as it relates to infection. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with pneumonia.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with pneumonia.

7) The nurse is caring for a client who develops a fever and productive cough after abdominal surgery. Which orders should the nurse expect from the healthcare provider? **Select all that apply.**
A) Sputum cultures
B) Antibiotics
C) Chest physiotherapy
D) Bronchial washing for culture
E) Isolation precautions
Answer: A, B, C
Explanation: A) The nurse would expect to obtain sputum cultures.
B) The nurse would expect to administer antibiotics.
C) The nurse would expect to perform chest physiotherapy to help clear the respiratory secretions.
D) Bronchial washings are not included in routine care for this situation.
E) Isolation precautions are usually not ordered for noncontagious infections.
Page Ref: 666
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 9.E. Analyze pneumonia as it relates to infection. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with pneumonia.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with pneumonia.

8) Which condition is *not* one of the four distinct patterns of pneumonia?
A) Lobar pneumonia
B) Bronchopneumonia
C) Alveolar pneumonia
D) Interstitial pneumonia
Answer: C
Explanation: A) The four distinct patterns of pneumonia include lobar pneumonia.
B) The four distinct patterns of pneumonia include bronchopneumonia.
C) Alveolar pneumonia is not a typical pattern for pneumonia.
D) The four distinct patterns of pneumonia include interstitial pneumonia.
Page Ref: 663
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.E. Analyze pneumonia as it relates to infection. Describe the pathophysiology of pneumonia.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with pneumonia.

9) Which type of pneumonia rarely occurs in individuals with normal immune function?
A) Pneumonia caused by the influenza virus

B) Pneumonia caused by *Pneumocystis jiroveci*
C) Pneumonia caused by *Mycoplasma pneumoniae*
D) Pneumonia caused by *Streptococcus pneumoniae*
Answer: B
Explanation: A) The influenza virus is a common cause of pneumonia in the general population.
B) Individuals who are significantly immunocompromised are at significant risk of developing pneumonia caused by *Pneumocystis jiroveci*. Immunity to *P. jiroveci* is nearly universal, except in those who are immunocompromised.
C) *Mycoplasma pneumoniae* is a common cause of pneumonia in the general population.
D) *Streptococcus pneumoniae* is a common cause of pneumonia in the general population.
Page Ref: 663
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.E. Analyze pneumonia as it relates to infection. Describe the etiology of pneumonia.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with pneumonia.

10) The provider has ordered fluid administration for a pediatric client with pneumonia. The client weighs 81.6 lb (37 kg). The nurse should expect to administer ________ mL of fluid per day for this client.
Answer: 1840
Explanation: Administer 100 mL/kg/day for the first 10 kg, 50 mL/kg/day for the second 10 kg, and 20 mL/kg/day for all additional body weight over 20 kg. Therefore, this client should receive (10 kg × 100 mL) + (10 kg × 50 mL) + (17 kg × 20 mL) = 1000 mL + 500 mL + 340 mL = 1840 mL/day.
Page Ref: 671
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.E. Analyze pneumonia as it relates to infection. Differentiate care of patients with pneumonia across the lifespan.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with pneumonia.

11) For which reason should adequate hydration be maintained in a client with pneumonia?
A) It helps maintain urine output to clear toxins from the blood.
B) It helps increase blood pressure to maintain perfusion to vital organs.
C) It helps keep the mucus membranes moist to prevent further infection.
D) It helps keep the airway clear by making secretions easier to expectorate.

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Answer: D
Explanation: A) For the client with pneumonia, adequate hydration is not done to clear toxins from the blood.
B) Adequate hydration is not maintained to support blood pressure in the client with pneumonia.
C) Adequate hydration is not maintained to prevent further infection in a client with pneumonia.
D) For clients with pneumonia, the most important reason to maintain adequate hydration is that this helps keep secretions in the lungs thin, which makes them easier to expectorate. This helps keep the airway clear, which is a priority for clients with pneumonia.
Page Ref: 671
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 9.E. Analyze pneumonia as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with pneumonia.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with pneumonia.

Exemplar 9.F Sepsis

1) A client is admitted to the intensive care unit with a systemic infection. Which manifestations will the nurse most likely assess in this client? **Select all that apply.**
A) Tachycardia
B) Pain
C) Edema
D) Hypotension
E) Fever
Answer: A, D, E
Explanation: A) Tachycardia is a common symptom of a systemic infection.
B) Pain is a symptom of a local infection.
C) Edema is a symptom of a local infection.
D) Hypotension is a common symptom of a systemic infection.
E) Fever is a common symptom of a systemic infection.
Page Ref: 676
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.F. Analyze sepsis as it relates to infection. Identify the clinical manifestations of sepsis.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with sepsis.

2) The nurse is providing teaching on preventing sepsis. Which finding should the nurse include as a major risk factor for the development of this health problem?
A) Pneumococcal bacteria
B) Leukocytosis on the complete blood count
C) Undiagnosed urinary tract infection
D) Elevated temperature
Answer: C
Explanation: A) Pneumococcal bacteria is not identified as a risk factor for the development of sepsis. Sepsis is most often the result of gram-positive infections from *Staphylococcus* and *Streptococcus* bacteria but may also follow gram-negative bacterial infections such as *Pseudomonas*, *Escherichia coli*, and *Klebsiella*.
B) Leukocytosis occurs with sepsis if the client is able to mount an immune response.
C) A portal of entry for sepsis is the urinary system.
D) An elevated temperature is a manifestation of sepsis.
Page Ref: 676
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.F. Analyze sepsis as it relates to infection. Describe the etiology of sepsis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with sepsis.

3) A 1-month-old infant is admitted to the hospital with a temperature of 102°F. For which reason should this infant be evaluated for sepsis?
A) Absence of sweat glands
B) Immature immune system
C) Inadequate red blood cells
D) Poor lung elasticity
Answer: B
Explanation: A) The child is not evaluated for sepsis because of the absence of sweat glands.
B) A child less than 3 months of age with a temperature higher than 100.4°F should be evaluated for sepsis because the child is at increased risk secondary to an immature immune system.
C) The child is not evaluated for sepsis because of inadequate red blood cells.
D) The child is not evaluated for sepsis because of poor lung elasticity.
Page Ref: 678
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 9.F. Analyze sepsis as it relates to infection. Differentiate care of patients with sepsis across the lifespan.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with sepsis.

4) The nurse is caring for a client with septicemia. Which assessment by the nurse best addresses the potential for inadequate peripheral tissue perfusion?
A) Monitor heart rate every hour.
B) Assess temperature every 4 hours.
C) Monitor pupil reactions every 8 hours.
D) Monitor for cyanosis.
Answer: D
Explanation: A) Heart rate is used to assess for cardiac output.
B) Temperature is assessed to determine the presence of an infection.
C) Pupil reaction is used to assess neurologic function.
D) A change in skin color will alert the nurse immediately of decreased tissue perfusion.
Page Ref: 679
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 9.F. Analyze sepsis as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with sepsis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with sepsis.

5) The nurse is caring for an older adult client who developed sepsis from a pressure ulcer while residing in a long-term care facility. The family asks how they can help prevent this from happening again in the future. Which response by the nurse is best?
A) Alert the staff when the client's IV runs dry.
B) Help the nurse with dressing changes.
C) Assist the client to the bathroom so there is not a fall.
D) Assist the client with meals to obtain optimal nourishment.
Answer: D
Explanation: A) The family is not responsible for IV monitoring.
B) The family is not responsible for dressing changes.
C) Assisting the client to the bathroom should be done by the staff who are responsible for client safety.
D) Poor nutritional status and a slow-functioning immune system contribute to the risk for sepsis in the older client. The family can help by assisting and encouraging the client to take in the proper nourishment needed.
Page Ref: 679
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.F. Analyze sepsis as it relates to infection. Differentiate care of patients with sepsis across the lifespan.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with sepsis.

W W . T B S M . N G

6) Which finding supports the nurse's evaluation that an older adult client with sepsis has maintained a normal mental status?
A) The client is agitated.
B) The client has a Glasgow coma score of 4.
C) The client responds to questions appropriately.
D) The client's pupils are fixed and dilated.
Answer: C
Explanation: A) Restlessness or agitation in a client with sepsis can be a sign that the client's condition is deteriorating.
B) The client with a Glasgow coma score of 4 is comatose.
C) A client who responds to questions appropriately is alert and oriented.
D) When pupils are fixed and do not respond to light, death is imminent.
Page Ref: 679
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 9.F. Analyze sepsis as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with sepsis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with sepsis.

7) The nurse is admitting a client to the intensive care unit. Earlier, the client presented to the emergency department in early septic shock. Which assessment findings should the nurse anticipate? **Select all that apply.**
A) Normal blood pressure
B) Rapid and deep respirations
C) Shallow respirations
D) Warm and flushed skin
E) Lethargic mental status
F) Decreased urine output
Answer: A, B, D
Explanation: A) Septic shock has an early phase and a late phase. Early-phase manifestations include normal blood pressure.
B) Septic shock has an early phase and a late phase. Early-phase manifestations include rapid and deep respirations.
C) Shallow respirations occur in the late phase of shock.
D) Septic shock has an early phase and a late phase. Early-phase manifestations include warm or flushed skin.
E) Lethargy occurs in the late phase of shock.
F) Decreased urine output occurs in the late phase of shock.
Page Ref: 677
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 9.F. Analyze sepsis as it relates to infection. Identify the clinical manifestations of sepsis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with sepsis.

8) In which order should the nurse list the pathophysiology concepts that occur in the development of sepsis?
A) Macrophage-producing cytokines are released.
B) Endotoxin released by microorganisms sets off an out-of-control inflammatory process.
C) Neutrophils arrive and multiply, occluding capillaries.
D) Vasodilation with increased capillary permeability and fluid leak.
Answer: B, A, D, C
Explanation: The pathophysiology of sepsis occurs as follows: Endotoxin released by microorganisms sets off an out-of-control inflammatory process; macrophage-producing cytokines are released; vasodilation with increased capillary permeability and fluid leak; neutrophils arrive and multiply, occluding capillaries.
Page Ref: 676
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 9.F. Analyze sepsis as it relates to infection. Describe the pathophysiology of sepsis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with sepsis.

9) Which action should the nurse take to prevent sepsis in a hospitalized client?
A) Use aseptic techniques when inserting a catheter.
B) Place clients with infections in negative airflow rooms.
C) Use airborne precautions when assessing clients.
D) Teach proper techniques for using tampons.
Answer: A
Explanation: A) One risk factor for developing sepsis is not using aseptic techniques and good hand washing techniques when inserting a catheter. Following standard guidelines for using aseptic and hand washing techniques when inserting or removing a catheter can help prevent sepsis.
B) Not all clients who are at risk for sepsis need to be placed in a negative airflow room.
C) Not all clients who are at risk for sepsis require airborne precautions during assessment.
D) Teaching proper techniques for using tampons will help prevent sepsis, but this is more appropriate for clients in the community rather than hospitalized clients.
Page Ref: 676
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.A.1. Examine human factors and other basic safety design principles as well as commonly used unsafe practices (such as, workarounds and dangerous abbreviations). | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Current best practices. | Nursing Process: Implementation
Learning Outcome: 9.F. Analyze sepsis as it relates to infection. Compare the risk factors and prevention of sepsis.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with sepsis.

10) Which diagnostic test result is consistent with a diagnosis of septic shock?
A) A blood pH that is higher than normal
B) A hematocrit that is higher than normal
C) A $PaCO_2$ that is lower than normal
D) A potassium level that is lower than normal
Answer: B
Explanation: A) During septic shock, the blood pH will be lower than normal (indicating acidosis).
B) During septic shock, fluid leaks from the intravascular to the extravascular spaces, causing hemoglobin and hematocrit concentrations that are higher than normal.
C) During septic shock, the $PaCO_2$ will increase.
D) During septic shock, the potassium level will increase.
Page Ref: 678
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.F. Analyze sepsis as it relates to infection. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with sepsis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with sepsis.

Exemplar 9.G Tuberculosis

1) The nurse is preparing to assess an older adult client admitted with tuberculosis. Which assessment finding does the nurse anticipate?
A) Night sweats
B) Swollen lymph nodes
C) Cough
D) Hemoptysis
Answer: C
Explanation: A) Night sweats are more common in younger adults but are not considered presenting symptoms of tuberculosis in the older adult.
B) Swollen lymph nodes are more common in younger adults but are not considered presenting symptoms of tuberculosis in the older adult.
C) Presenting symptoms of tuberculosis in the older adult are often vague and include coughing, weight loss, diminished appetite, and periodic fevers.
D) Hemoptysis is more common in younger adults but is not considered a presenting symptom of tuberculosis in the older adult.
Page Ref: 690
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.G. Analyze tuberculosis as it relates to infection. Differentiate care of patients with tuberculosis across the lifespan.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with tuberculosis.

2) An adolescent client is brought to the emergency department (ED) with fatigue, weight loss, a dry cough, and night sweats. The family just recently immigrated to the United States. Based on this data, which potential risk should the nurse include when planning care for this client?
A) Pneumothorax
B) Atelectasis
C) Renal failure
D) Reduced peristalsis
Answer: A
Explanation: A) This client was foreign-born, a risk factor for tuberculosis (TB), and has the classic symptoms of tuberculosis. The nurse plans frequent respiratory assessments, as this child is at risk for pneumothorax.
B) Clients with TB are not at particular risk for atelectasis.
C) Clients with TB are not at particular risk for renal failure.
D) Clients with TB are not at particular risk for reduced peristalsis.
Page Ref: 685
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 9.G. Analyze tuberculosis as it relates to infection. Identify the clinical manifestations of tuberculosis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with tuberculosis.

3) The nurse is providing a health screening for a homeless client with a history of drug abuse. The client has a chronic, nonproductive cough. For which should the nurse expect to screen this client?
A) Herpes zoster
B) Sickle cell disease
C) Sick sinus syndrome
D) Tuberculosis
Answer: D
Explanation: A) There is no evidence to support the need to screen the client for herpes zoster.
B) There is no evidence to support the need to screen the client for sickle cell disease.
C) There is no evidence to support the need to screen the client for sick sinus syndrome.
D) The homeless client who abuses drugs is at risk for contracting tuberculosis (TB); therefore, the nurse would expect to screen this client for TB.
Page Ref: 683
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 9.G. Analyze tuberculosis as it relates to infection. Compare the risk factors and prevention of tuberculosis.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with tuberculosis.

4) The nurse is planning care for a client recently diagnosed with tuberculosis (TB). The client lives alone in an apartment and will continue treatment at home. When reviewing the client's history, the nurse notes that the client has had trouble complying with medication regimens in the past. Which problem is a priority for this client?

A) Inadequate health maintenance skills
B) Lack of knowledge about TB
C) Risk for infection
D) Poor community health

Answer: A

Explanation: A) The treatment regimen for tuberculosis requires that the client take many medications, maintain nutrition, and be aware of potential side effects. Given the complexity of this regimen and the client's history of noncompliance, the client is at risk for inadequate health maintenance skills.

B) The client may lack knowledge about TB but the priority is the health management.

C) The client has an infection.

D) There is no evidence that the client is at risk for poor community health.

Page Ref: 690-691

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 9.G. Analyze tuberculosis as it relates to infection. Differentiate care of patients with tuberculosis across the lifespan.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with tuberculosis.

5) An occupational health nurse is screening a new employee in a long-term care facility for tuberculosis (TB). The employee questions why purified protein derivative (PPD) testing is done twice. Which response should the nurse make?
A) "Different medication is used in the second PPD."
B) "The treatment for TB is 6 months of medication, and we want to make sure the first results of the first PPD were accurate."
C) "The first PPD was not interpreted in the correct time frame of 48-72 hours."
D) "There is an increased risk for a false-negative response for people who work in long-term care facilities. The two-step process is recommended to accurately screen for TB."
Answer: D
Explanation: A) PPD testing is not done twice because different medication is used.
B) Treatment for TB for 6 months is not a reason to complete the PPD twice.
C) Evaluating the test at the wrong interval is not the reason that the PPD is done twice for long-term care facility employees.
D) PPD testing is done in a two-step process for people who work in long-term care facilities because of the risk of false-negative responses.
Page Ref: 690
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 9.G. Analyze tuberculosis as it relates to infection. Compare the risk factors and prevention of tuberculosis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with tuberculosis.

6) The nurse has provided teaching on multidrug treatment to a client with tuberculosis. Which statement by the client indicates that the teaching was effective?
A) "Multiple drugs are necessary to develop immunity to tuberculosis."
B) "Multiple drugs are necessary because I became infected from an immigrant."
C) "Multiple drugs will be required as long as I am contagious."
D) "Multiple drugs are necessary because of the risk of resistance."
Answer: D
Explanation: A) Drugs to treat tuberculosis do not cause immunity to the disease.
B) There is no indication that the client contracted TB from an immigrant.
C) Treatment must be continued long after the client is no longer contagious.
D) Tuberculosis bacilli are likely to develop resistance to one drug, so multiple drugs must be used.
Page Ref: 686
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 9.G. Analyze tuberculosis as it relates to infection. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with tuberculosis.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with tuberculosis.

7) The nurse is caring for a client who is admitted to the unit with tuberculosis (TB). Which type of isolation room is most appropriate?
A) Single-door room with positive airflow (air flows out of the room)
B) Isolation room with an anteroom and negative airflow (air flows into the room)
C) Isolation room with an anteroom and normal airflow
D) Single-door room with normal airflow
Answer: B
Explanation: A) Single-door rooms are not equipped to have positive or negative airflow.
B) Patients with airborne infections such as meningococcemia, severe acute respiratory syndrome (SARS), or TB are placed in an isolation room with an anteroom and negative pressure airflow. Air flows into the room and is vented in a special manner to prevent the organism from entering the rest of the unit.
C) Positive flow rooms are used for those clients who are immunosuppressed so that microorganisms from the unit are not drawn into the room.
D) Single-door isolation with normal airflow might be used for a client with droplet or wound infection.
Page Ref: 692
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.G. Analyze tuberculosis as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with tuberculosis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with tuberculosis.

8) The charge nurse for a medical-surgical unit is notified that a client with tuberculosis (TB) is being transported to the unit. Which actions for infection prevention are the most appropriate in this circumstance? **Select all that apply.**
A) Stock the client's supply cart at the beginning of each shift.
B) Wear a respirator and gown when caring for the client.
C) Have the client wear a mask when coming from admissions.
D) Perform hand hygiene only after leaving the room.
E) Test all staff members for TB immediately.
Answer: B, C
Explanation: A) Supplies to prevent transmission of disease should be stocked at the end of the shift so that adequate supplies will be available for the next healthcare provider.
B) HEPA-filtered respirators and gowns should be worn when caring for clients who do not reliably cover their mouths when coughing.
C) When a client has an airborne disease and must go elsewhere in the hospital, the client must wear a mask.
D) Hand hygiene should be performed before and after client care.
E) Clinical staff receive TB testing annually. There is no reason to test all staff members at this time.
Page Ref: 692
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 5.3 Contribute to a culture of provider and work environment safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.G. Analyze tuberculosis as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with tuberculosis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with tuberculosis.

9) The nurse is caring for a client with tuberculosis (TB) who is taking rifampin for treatment of the disease. Which nursing interventions are appropriate for this client? **Select all that apply.**
A) Administer the medication with meals to reduce gastrointestinal side effects.
B) Record a baseline visual examination before initiating therapy.
C) Administer the medication on an empty stomach.
D) Administer the medication by deep intramuscular injection into a large muscle mass.
E) Monitor complete blood count (CBC), liver function studies, and renal function studies for evidence of toxicity.
Answer: C, E
Explanation: A) Rifampin is taken on an empty stomach.
B) A baseline visual examination before therapy is necessary with ethambutol, another antituberculosis medication.
C) Rifampin should be administered on an empty stomach.
D) Rifampin is an oral antituberculosis medication.
E) The nurse should monitor the CBC, liver function studies, and renal function studies.
Page Ref: 688, 692
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.G. Analyze tuberculosis as it relates to infection. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with tuberculosis.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with tuberculosis.

10) The nurse caring for a client at risk for tuberculosis (TB) should include which symptoms of the disease when educating the client? **Select all that apply.**
A) Fatigue
B) Low-grade morning fever
C) Productive cough that later turns to a dry, hacking cough
D) Weight loss
E) Night sweats
Answer: A, D, E
Explanation: A) Manifestations of tuberculosis often develop insidiously and are initially nonspecific. Fatigue is common.
B) Manifestations of tuberculosis include a low-grade fever in the afternoon.
C) A dry cough develops, which later becomes productive of purulent and/or blood-tinged sputum.
D) Manifestations of tuberculosis include weight loss.
E) Manifestations of tuberculosis include night sweats.
Page Ref: 685
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.G. Analyze tuberculosis as it relates to infection. Identify the clinical manifestations of tuberculosis.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with tuberculosis.

11) A client with a previously healed tuberculosis lesion experiences lesion rupture that leads to active disease. Which type of tuberculosis does this client have?
A) Miliary tuberculosis
B) Extrapulmonary tuberculosis
C) Reactivation tuberculosis
D) Cavitation tuberculosis
Answer: C
Explanation: A) Miliary tuberculosis is the spread of tuberculosis through the blood to the rest of the body.
B) Extrapulmonary tuberculosis is tuberculosis outside of the lungs.
C) When a previously healed tuberculosis lesion ruptures and initiates active disease, this is called reactivation tuberculosis.
D) Cavitation is a process by which a bubble or cavity is formed from tuberculosis infection. It is not a type of tuberculosis.
Page Ref: 682
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.G. Analyze tuberculosis as it relates to infection. Describe the pathophysiology of tuberculosis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with tuberculosis.

12) A client asks what caused the disease tuberculosis (TB). Which organism should the nurse respond is causing the condition?
A) *Micrococcus tuberculosis.*
B) *Microbacterium tuberculosis*.
C) *Mycoplasma tuberculosis*.
D) *Mycobacterium tuberculosis*.
Answer: D
Explanation: A) *Micrococcus tuberculosis* is another form of bacteria but does not cause tuberculosis.
B) *Microbacterium tuberculosis* is another form of bacteria but does not cause tuberculosis.
C) *Mycoplasma* tuberculosis is another form of bacteria but does not cause tuberculosis.
D) Tuberculosis is caused by the bacterium *Mycobacterium tuberculosis*.
Page Ref: 682
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.G. Analyze tuberculosis as it relates to infection. Describe the etiology of tuberculosis.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with tuberculosis.

Exemplar 9.H Urinary Tract Infection

1) An adult client is admitted to the hospital with a diagnosis of kidney stones. The healthcare provider prescribes IV fluids, x-rays, blood work, and an indwelling urinary catheter for the client. The nurse is caring for the client 3 days after admission and documents morning vital signs of 101°F, heart rate 92, respirations 25, and blood pressure 120/80. The urinary output has decreased, and the urine is cloudy and dark amber. Based on this data, which conclusion by the nurse is the most appropriate?
A) The client has passed the kidney stones.
B) The client is in acute renal failure.
C) The client has developed a respiratory infection.
D) The client has a probable urinary tract infection.
Answer: D
Explanation: A) There is no evidence the client passed the kidney stones.
B) There is no evidence the client is in renal failure.
C) There is no evidence of a respiratory infection.
D) The client has developed a urinary tract infection that was not present upon admission. This is a healthcare-associated infection (HAI) and is likely due to poor technique when inserting the indwelling urinary catheter.
Page Ref: 696, 698
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.H. Analyze urinary tract infection as it relates to infection. Identify the clinical manifestations of urinary tract infections.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with urinary tract infection.

WW.TESTBANKS

2) The nurse for a urology clinic is planning an in-service about urinary infections for a group of novice nurses. Which statement should the nurse include in the presentation?
A) Men are most likely to experience descending urinary tract infections.
B) Straight catheterization is the only way to evaluate for the presence of a urinary tract infection.
C) Women require a shorter course of antibiotic therapy to manage a urinary tract infection than men.
D) The rate of urinary tract infections is similar between men and women.
Answer: C
Explanation: A) Descending infections are less common than ascending infections of the urinary tract.
B) A clean-catch midstream specimen is a reliable means to obtain a urine specimen to check for the presence of infection.
C) Men will usually be prescribed a longer course of therapy to manage a urinary tract infection. They have a longer urethra and typically experience more complicated urinary tract infections than women.
D) Women have a higher rate of urinary tract infection than men.
Page Ref: 700
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 9.H. Analyze urinary tract infection as it relates to infection. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with urinary tract infection.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with urinary tract infection.

3) The nurse is providing teaching to the family of an older adult client with a urinary tract infection (UTI). Which common early symptom that is likely to occur in older adults should the nurse stress?
A) Urinary urgency
B) Blood in the urine
C) Urinary frequency
D) Alteration in cognition
Answer: D
Explanation: A) Urinary urgency is not a common early symptom of a UTI in an older adult.
B) Blood in the urine is not a common early symptom of a UTI in an older adult.
C) Urinary frequency is not a common early symptom of UTI in an older adult.
D) Older adult clients are often asymptomatic until changes in cognition occur.
Page Ref: 701
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 9.H. Analyze urinary tract infection as it relates to infection. Differentiate care of patients with urinary tract infection across the lifespan.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with urinary tract infection.

4) Which question best helps the nurse establish a common cause of recurrent urinary tract infections (UTIs) in a preadolescent female client?
A) "When was your last UTI?"
B) "How often do you shower?"
C) "Do you have a family history of urinary problems?"
D) "In what direction do you wipe after a bowel movement?"
Answer: D
Explanation: A) The nurse would have the information about the client's last UTI.
B) Personal hygiene practices, such as cleansing after a bowel movement, are a priority teaching instruction to include for this client.
C) Urinary tract infections are not associated with families or genetics.
D) The most important teaching to provide females is always to wipe the perianal/genital area from front to back. *Escherichia coli* are the most common microorganisms responsible for urinary tract infections and can easily be dragged into the urethral orifice by wiping from the anus to the urethra after defecation. Females do have a shorter urethra compared with males and are more susceptible to urinary tract infections for this reason.
Page Ref: 697
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 9.H. Analyze urinary tract infection as it relates to infection. Compare the risk factors and prevention of urinary tract infections.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with urinary tract infection.

5) The nurse is providing teaching to parents about urinary tract infections (UTIs) in preschool children. The nurse should inform the parents that which symptoms of UTI are common in this age group? **Select all that apply.**
A) Urinary urgency
B) Elevated blood pressure
C) Dysuria
D) Fever
E) Headache
Answer: A, C, D
Explanation: A) Clinical manifestations of a UTI in a preschool-aged child includes urgency.
B) Elevated blood pressure is not a clinical manifestation of a UTI in a preschool-aged child.
C) Clinical manifestations of a UTI in a preschool-aged child includes dysuria.
D) Clinical manifestations of a UTI in a preschool-aged child includes a fever.
E) Headache is not a clinical manifestation of a UTI in a preschool-aged child.
Page Ref: 700
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.H. Analyze urinary tract infection as it relates to infection. Identify the clinical manifestations of urinary tract infections.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with urinary tract infection.

6) The nurse is providing discharge teaching for a client diagnosed with a urinary tract infection (UTI). The client is prescribed a 3-day course of oral trimethoprim-sulfamethoxazole (TMP-SMZ). Which client statement indicates that teaching has been effective?
A) "I will return within 10 days for a follow-up urine culture."
B) "I will practice Kegel exercises on a daily basis."
C) "I will increase my intake of fluids, especially citrus juice."
D) "I will only wear 100% cotton underwear."
Answer: A
Explanation: A) It is essential to validate eradication of infection with a follow-up culture that is negative.
B) Doing Kegel exercises does not evaluate the effectiveness of teaching about the treatment for a UTI.
C) Citrus juices are not recommended because they irritate the bladder and have no effect on urine acidity.
D) Wearing cotton underwear is a prevention measure; however, it does not evaluate the effectiveness of teaching about the treatment for a UTI.
Page Ref: 699-700
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 9.H. Analyze urinary tract infection as it relates to infection. Apply the nursing process in providing culturally competent care to an individual with a urinary tract infection.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with urinary tract infection.

7) The healthcare provider prescribes an indwelling urinary catheter for a client with urinary retention. Which intervention, along with strict aseptic technique, will decrease the risk of infection for this procedure?
A) Irrigating the catheter with sterile saline on a daily basis
B) Instructing the client to void around the catheter
C) Inserting the catheter to the full recommended length
D) Inflating the balloon while the catheter is in the urethra
Answer: C
Explanation: A) Irrigating the catheter should not be done because it can introduce infection by allowing bacteria to enter the closed urinary drainage system.
B) Although voiding around the catheter will decrease bladder spasms, it will not help reduce infection.
C) An action to prevent infection with an indwelling urinary catheter is to insert it to the full recommended length before inflating the balloon.
D) The balloon is not inflated until the catheter is in the bladder, in order to prevent trauma to the urethra and therefore decrease the risk of infection.
Page Ref: 703
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.H. Analyze urinary tract infection as it relates to infection. Compare the risk factors and prevention of urinary tract infections.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with urinary tract infection.

8) The nurse in an urgent care center assesses a 40-year-old adult client who presents with a fever of 101.2°F and complaints of painful urination. Which question should the nurse ask to elicit further data that indicate cystitis?
A) "Do you have any symptoms of menopause?"
B) "How long have you had a fever, and have you had chills with this?"
C) "Do you have any upper abdominal pain or cramping?"
D) "What color is your urine?"
Answer: D
Explanation: A) A 40-year-old client who presents with a fever and painful urination is not experiencing symptoms of menopause.
B) Asking about fever and chills is not specific to suspected cystitis and does not elicit information related to urinary symptoms.
C) Pain from cystitis is typically suprapubic, not upper abdominal.
D) The classic symptoms of cystitis include dysuria or painful urination, urinary frequency and urgency, and bloody urine or hematuria.
Page Ref: 696
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 9.H. Analyze urinary tract infection as it relates to infection. Identify the clinical manifestations of urinary tract infections.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with urinary tract infection.

9) The nurse is creating a teaching tool about urinary tract infections. Which type of infection should the nurse explain about that results from bacteria ascending to the kidney from the lower urinary tract?
A) Urethritis
B) Prostatitis
C) Pyelonephritis
D) Cystitis
Answer: C
Explanation: A) Urethritis is a lower urinary tract infection.
B) Prostatitis is a lower urinary tract infection.
C) Pyelonephritis is inflammation of the renal pelvis and parenchyma. This is the most common upper urinary tract infection.
D) Cystitis is a lower urinary tract infection.
Page Ref: 696
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.H. Analyze urinary tract infection as it relates to infection. Describe the pathophysiology of urinary tract infections.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with urinary tract infection.

10) Which source of bacteria should the nurse explain as being the most common for the development of a urinary tract infection (UTI)?
A) An indwelling urinary catheter
B) Mucous membranes of the perineal area
C) The hands
D) Clothing such as underwear
Answer: B
Explanation: A) The presence of an indwelling urinary catheter is a risk factor for development of a UTI, but the source of bacteria is not the catheter itself.
B) Pathogens usually enter the urinary tract by ascending from the mucous membranes of the perineal area into the lower urinary tract. The source of bacteria is still often the mucous membranes of the perineal tract.
C) The hands are potential sources of bacteria that cause a UTI, but they are not the most common.
D) Clothing is a potential source of bacteria that cause a UTI, but is not the most common.
Page Ref: 696
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 9.H. Analyze urinary tract infection as it relates to infection. Describe the etiology of urinary tract infections.

MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with urinary tract infection.

11) The nurse is caring for a 6-year-old client with a urinary tract infection (UTI). Which nursing outcome is appropriate for this client?
A) Bilirubin levels will remain within normal limits.
B) No episodes of enuresis.
C) Remain afebrile for 12 hours prior to discharge.
D) Void at least 300 mL of urine over 24 hr.
Answer: B
Explanation: A) An outcome related to bilirubin levels would be more appropriate for a neonate, not a school-aged child.
B) Children who are potty trained often develop enuresis, or involuntary passage of urine, during a urinary tract infection. An appropriate nursing outcome would be that the child would recover enough from the infection that the child no longer experiences enuresis.
C) The client should be afebrile for 24 hours prior to discharge, not 12 hours.

D) The client should be voiding 500 to 1000 mL of urine in 24 hours, depending on weight. Only voiding 300 mL of urine would be cause for concern.
Page Ref: 700
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 9.H. Analyze urinary tract infection as it relates to infection. Differentiate care of patients with urinary tract infection across the lifespan.
MNL LO: Demonstrate understanding of the concept of infection in the care of a patient with urinary tract infection.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 10 Inflammation

The Concept of Inflammation

1) The nurse is caring for a client who has experienced a sports-related injury to the knee. During the morning assessment, which signs of inflammation should the nurse anticipate? **Select all that apply.**
A) Pitting edema
B) Pallor
C) Swelling
D) Warmth
E) Pain
Answer: C, D, E
Explanation: A) Pitting edema is not a sign of inflammation.
B) Pallor is not a sign of inflammation.
C) Swelling is a sign of inflammation.
D) Warmth is a sign of inflammation.
E) Pain is a sign of inflammation.
Page Ref: 710
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.1. Analyze the physiology of inflammation in the body.
MNL LO: Analyze the concept of inflammation and its application to nursing care.

2) A client is admitted to the hospital with airway edema, bronchoconstriction, and increased mucus production after being exposed to an allergen. Which nursing interventions are appropriate to address this inflammation to the client's respiratory system? **Select all that apply.**

A) Turn and reposition every 2 hours
B) Monitor oxygen saturation
C) Administer oxygen as prescribed
D) Restrict fluids
E) Monitor lung sounds

Answer: B, C, E

Explanation: A) Turning and repositioning every 2 hours would be appropriate to maintain tissue integrity but not to address respiratory inflammation.

B) Monitoring oxygen saturation would be appropriate care for a client who is experiencing inflammation of the respiratory system.

C) Administering oxygen would be appropriate care for a client who is experiencing inflammation of the respiratory system.

D) Restricting fluids could cause respiratory secretions to thicken and hinder the client's ability to maintain a clear airway. Fluids should be encouraged.

E) Monitoring lung sounds would be appropriate care for a client who is experiencing inflammation of the respiratory system.

Page Ref: 714
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.3. Outline the relationship between inflammation and other concepts.
MNL LO: Analyze the concept of inflammation and its application to nursing care.

3) The nurse is providing instructions to a client who has been prescribed a nonsteroidal anti-inflammatory drug (NSAID). Which information is highest priority for the nurse to explain to the client about this medication?
A) "Take your medication on an empty stomach."
B) "Take with your morning aspirin dose."
C) "Constipation is common with your medication, so include roughage in your diet."
D) "Take your medication with food."
Answer: D
Explanation: A) Taking NSAIDs on an empty stomach can precipitate gastric irritation.
B) Nonsteroidal anti-inflammatory drugs (NSAIDs) can precipitate bleeding if taken with an anticoagulant such as aspirin.
C) Constipation is not an issue with NSAIDs.
D) Taking NSAIDs with food is recommended because doing so will decrease gastrointestinal (GI) irritation.
Page Ref: 720
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.7. Summarize collaborative therapies used by interprofessional teams for patients with inflammation.
MNL LO: Analyze the concept of inflammation and its application to nursing care.

WwW.TbSm.Wg

4) The nurse is caring for a client with severe inflammation. Which assessment findings would indicate a systemic reaction to inflammation? **Select all that apply.**
A) Erythema
B) Edema
C) Pain
D) Tachypnea
E) Tachycardia
Answer: D, E
Explanation: A) Erythema is a local reaction to inflammation.
B) Edema is a local reaction to inflammation.
C) Pain is a local reaction to inflammation.
D) Systemic manifestations of infection include tachypnea.
E) Systemic manifestations of infection include tachycardia.
Page Ref: 717
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.5. Differentiate common assessment procedures and tests used to examine inflammation.
MNL LO: Analyze the concept of inflammation and its application to nursing care.

5) The nurse in a rheumatology clinic is managing care for clients who receive nonsteroidal anti-inflammatory drugs (NSAIDs) for the treatment of their disease processes. Which primary laboratory tests should the nurse assess prior to initiation of NSAID therapy? **Select all that apply.**

A) Serum amylase

B) Electrolytes

C) Hemoglobin

D) White blood cell count (WBC)

E) Liver function tests

Answer: D, E

Explanation: A) There is no need to assess the client's serum amylase before giving NSAIDs.

B) There is no need to assess the client's electrolytes before giving NSAIDs.

C) There is no need to assess the client's hemoglobin before giving an NSAID.

D) It is important to assess the client's WBC count to determine the presence of an infection which could be masked by the effects of the NSAID.

E) It is important to assess the client's liver function test prior to beginning NSAID therapy.

Page Ref: 717

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 10.7. Summarize collaborative therapies used by interprofessional teams for patients with inflammation.

MNL LO: Analyze the concept of inflammation and its application to nursing care.

6) The nurse is providing care to a client who experiences chronic inflammation due to arthritis. For which collaborative intervention should the nurse plan when providing care to this client?
A) Administering anti-inflammatory medications
B) Administering diuretics
C) Administering frequent doses of opioid medications
D) Administering antibiotics
Answer: A
Explanation: A) Anti-inflammatory medication will reduce the pain and inflammation caused by arthritis.
B) Diuretics are not used to treat the inflammatory process.
C) Opioid medication is not usually indicated to treat a chronic inflammatory process.
D) Antibiotics would be ordered for an infection, not for chronic inflammation.
Page Ref: 718
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 10.7. Summarize collaborative therapies used by interprofessional teams for patients with inflammation.
MNL LO: Analyze the concept of inflammation and its application to nursing care.

WwW.TbSm.Wg

7) The nurse is caring for a client who has extensive deep tissue damage. The nurse notes that the client is also vegan. Which dietary information should the nurse teach this client to enhance the healing process?
A) "A low-fat, high-carbohydrate, low-protein diet is best for healing."
B) "A high-fat, low-carbohydrate diet is best for healing."
C) "A high-carbohydrate, high-protein diet is best for healing."
D) "A diet high in protein and vitamin D is best for healing."
Answer: C
Explanation: A) Carbohydrates are important to meet the energy demands of healing, and protein is needed for cell growth. This client needs to be taught to eat proteins that provide the essential amino acids that can be lacking in a vegan diet. Fats are needed in moderation for the development of cell membranes.
B) Carbohydrates are important to meet the energy demands of healing, and protein is needed for cell growth. This client needs to be taught to eat proteins that provide the essential amino acids that can be lacking in a vegan diet. Fats are needed in moderation for the development of cell membranes.
C) Carbohydrates are important to meet the energy demands of healing, and protein is needed for cell growth. This client needs to be taught to eat proteins that provide the essential amino acids that can be lacking in a vegan diet.
D) Protein is needed for cell growth. Vitamins necessary to promote healing are C, K, A, and the B-complex vitamins.
Page Ref: 718
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 10.6. Analyze independent interventions nurses can implement for patients with inflammation.
MNL LO: Analyze the concept of inflammation and its application to nursing care.

8) The nurse instructs an older adult client with arthritis on the side effects of nonsteroidal anti-inflammatory drug (NSAID) therapy. Which client statement would indicate that this teaching has been effective?

A) "I will report any abnormal bruising."

B) "Caffeine decreases the effectiveness of the medication."

C) "I cannot take other medications while using NSAIDs."

D) "If I notice a change in my mood after starting NSAID therapy, I will call the prescriber."

Answer: A

Explanation: A) Older adult clients are at risk for increased bleeding with NSAID therapy. Thus, the client should be taught to report any abnormal bruising, which may indicate bleeding.

B) There is no reason for avoiding caffeine while using an NSAID.

C) Older adult clients often take several medications, and refraining from taking them with NSAIDs is an unrealistic outcome.

D) Mood changes are not a side effect of NSAID therapy.

Page Ref: 720

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 10.8. Differentiate considerations related to the assessment and care of patients with inflammation throughout the lifespan.

MNL LO: Analyze the concept of inflammation and its application to nursing care.

9) The warmth and redness that accompany inflammation result from which step in the inflammatory process?
A) Exudate production
B) Cellular regeneration
C) Hyperemia
D) Margination of leukocytes
Answer: C
Explanation: A) Exudate production occurs later in the inflammatory process and involves the release of fluid, dead cells, and cellular products from the injured area.
B) Cellular regeneration occurs during the last stage of the inflammatory process and does not cause redness or warmth.
C) Immediately after injury or infection, the damaged tissues release histamines, kinins, and prostaglandins. These substances serve as chemical mediators to dilate blood vessels, causing more blood to flow to the injured area. This increase in blood supply is called hyperemia and is responsible for the characteristic signs of redness and heat that accompany inflammation.
D) Margination refers to the process by which leukocytes aggregate along the inner surface of blood vessels in an injured area.
Page Ref: 710
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.1. Analyze the physiology of inflammation in the body.
MNL LO: Analyze the concept of inflammation and its application to nursing care.

10) In the presence of inflammation, a client's erythrocyte sedimentation rate (ESR)
A) decreases due to the decreased proportion of fibrinogen in the blood.
B) decreases due to the increased proportion of fibrinogen in the blood.
C) increases due to the decreased proportion of fibrinogen in the blood.
D) increases due to the increased proportion of fibrinogen in the blood.
Answer: D
Explanation: A) The ESR level will not decrease when inflammation is present.
B) The ESR level will not decrease when inflammation is present.
C) The ESR level will not increase because of a decrease in the proportion of fibrinogen in the blood.
D) When an inflammatory process is active, the increased proportion of fibrinogen in a client's blood causes the red blood cells to stick to one another and settle faster. This, in turn, results in a higher ESR reading.
Page Ref: 717
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.5. Differentiate common assessment procedures and tests used to examine inflammation.
MNL LO: Analyze the concept of inflammation and its application to nursing care.

11) The nurse is providing instruction to the parents of a pediatric client who is experiencing inflammation due to respiratory infection. Which point would be most appropriate for the nurse to include as part of this teaching?
A) "Try to keep your child in a supine position to promote more effective oxygenation."
B) "Adequate fluid intake is even more important for children with inflammation than for adults with inflammation."
C) "If your child seems to be gasping for air, encourage him to tuck his chin against his chest."
D) "Rapid heartbeat is an early sign of dehydration and low blood volume in children."
Answer: B
Explanation: A) As compared to adults, children have a larger tongue relative to the oral cavity, decreased airway muscle tone, a shorter epiglottis, a more anteriorly positioned larynx, a shorter and narrower trachea, and prominent adenoid and lymphoid tissue. These factors increase a child's risk of airway obstruction, especially when the child is supine.
B) Because of children's small size, absolute volumes of fluid loss represent a larger proportion of total body fluid. For this reason, adequate fluid intake is especially important for pediatric clients with inflammation.
C) As compared to adults, children have a larger tongue relative to the oral cavity, decreased airway muscle tone, a shorter epiglottis, a more anteriorly positioned larynx, a shorter and narrower trachea, and prominent adenoid and lymphoid tissue. These factors increase a child's risk of airway obstruction, especially when the neck is hyperflexed.
D) Tachycardia is frequently a late symptom of hypovolemia in children.
Page Ref: 721
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.8. Differentiate considerations related to the assessment and care of patients with inflammation throughout the lifespan.
MNL LO: Analyze the concept of inflammation and its application to nursing care.

12) The nurse is teaching the family of a school-age client diagnosed with inflammatory bowel disease regarding the administration of prednisone at home. At which time should the nurse instruct the parents to provide this medication to the client?
A) 1 hour before meals
B) At bedtime
C) With meals
D) Between meals
Answer: C
Explanation: A) It should not be given on an empty stomach.
B) It should not be given at bedtime.
C) Prednisone, a corticosteroid, can cause gastric irritation. It should be administered with meals to reduce this irritation.
D) It should not be given on an empty stomach.
Page Ref: 719
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.7. Summarize collaborative therapies used by interprofessional teams for patients with inflammation.
MNL LO: Analyze the concept of inflammation and its application to nursing care.

Exemplar 10.A Appendicitis

1) A client is admitted to the hospital with an elevated temperature, nausea, and pain and tenderness in the lower right quadrant of the abdomen. After receiving pain medication, the client continues to complain of pain at a level of 8 on a 0-10 pain scale. The client is not scheduled to receive pain medications for at least another 2 hours. Given these circumstances, which statement by the nurse is most appropriate?
A) "I will inform the healthcare provider about your continued pain."
B) "I do not have any medications ordered for you at this time."
C) "Try to rest for a while longer until it is time to receive your medication."
D) "Let's try a heating pad or warm blanket to see if that helps with your discomfort."
Answer: A
Explanation: A) The client's inability to achieve comfort will need to be reported to the physician. The reported manifestations are consistent with appendicitis, so the client is at risk for perforation, which is manifested by increased pain.
B) Advising the client that no medications are available at this time does not meet the concerns being presented by the client.
C) Advising the client to rest does not meet the concerns being presented by the client.
D) The use of heat to manage the pain is contraindicated due to the risk of perforation.
Page Ref: 723
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.A. Analyze appendicitis as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with appendicitis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with appendicitis.

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2) A client with acute abdominal pain is scheduled for an appendectomy in 3 hours. While waiting for the surgery, the client reports that the pain has subsided. Which action should the nurse take?

A) Determine when the client can be medicated for pain
B) Contact the surgery department
C) Contact the healthcare provider
D) Notify the nursing supervisor

Answer: C

Explanation: A) The next time the client can be medicated for pain is not relevant in this situation.

B) Notification of the surgery department should not be completed before contacting the healthcare provider.

C) The pain relief being experienced by the client is consistent with rupture of the appendix. In the case of suspected rupture, the healthcare provider should be notified immediately, because if the appendix has ruptured, the client's risk for peritonitis will increase.

D) Notification of the nursing supervisor should not be completed before contacting the healthcare provider.

Page Ref: 726

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 10.A. Analyze appendicitis as it relates to inflammation. Identify the clinical manifestations of appendicitis.

MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with appendicitis.

3) An adult female client develops signs and symptoms of appendicitis during the night. The client is brought to the emergency department by her family. Which nursing intervention is the most culturally sensitive for this client?
A) Ask the healthcare provider who should assess the client.
B) Ask for a female healthcare provider to assess the client.
C) Ask for a male healthcare provider to assess the client.
D) Explain the assessment procedure and ask the client and family their preference.
Answer: D
Explanation: A) Asking the healthcare provider to decide who assesses the client does not take into account the client's wishes.
B) The nurse should not assume that a client will want a female healthcare provider.
C) The nurse should not assume that a client will want a male healthcare provider.
D) Culturally competent care means collaborating with the client to determine their preferences for medical care.
Page Ref: 725
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 10.A. Analyze appendicitis as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with appendicitis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with appendicitis.

4) The nurse is caring for a pediatric client recovering from surgery for a perforated appendix. Which problem should the nurse use to guide this client's care during the immediate postoperative period?
A) Chronic pain
B) Fear
C) Potential for fluid volume deficit
D) Risk for infection
Answer: D
Explanation: A) Because the client is recovering from an appendectomy, the client will most likely have acute pain.
B) There is no evidence to suggest the client is afraid since the surgery has already occurred.
C) There is no evidence to suggest the client is at risk for deficient fluid volume.
D) Because the appendix ruptured before surgery, the client is at risk for infection, specifically peritonitis.
Page Ref: 725
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 10.A. Analyze appendicitis as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with appendicitis.

MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with appendicitis.

5) The nurse, caring for an older school-age client recovering from an appendectomy, is preparing to help the family ambulate the child for the first time after surgery. Which nonpharmacologic nursing strategy would be most appropriate for this client?
A) Placing a warm, moist pack over the site of the incision
B) Holding a splint pillow against the abdomen when moving or coughing
C) Administering appropriate narcotic analgesics
D) Applying an ice pack over the site of the incision
Answer: B
Explanation: A) A splint pillow placed on the abdomen is a nonpharmacologic strategy to decrease discomfort after an appendectomy. Heat is not used on the incision area, as it can impair the healing process of the wound.
B) A splint pillow placed on the abdomen is a nonpharmacologic strategy to decrease discomfort after an appendectomy.
C) Administering a narcotic is considered a pharmacologic nursing strategy.
D) Ice is not used on the incision area, as it can impair the healing process of the wound.
Page Ref: 726
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.A. Analyze appendicitis as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with appendicitis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with appendicitis.

6) A client with appendicitis is highly agitated and reports a great deal of pain. Which intervention will help decrease this client's anxiety?
A) Assess pain levels every 2 hours and administer ordered medication.
B) Provide reading material to help distract the client.
C) Distract the client with ambulation.
D) Administer pain medications when the client complains of pain.
Answer: A
Explanation: A) The extreme pain caused by appendicitis is the source of the client's anxiety. Assessing the client's pain level every 2 hours and administering medications before the pain gets intense is the best intervention to help decrease the client's anxiety.
B) Distraction does not work when clients have severe pain but is often appropriate for those with chronic pain.
C) Distraction does not work when clients have severe pain but is often appropriate for those with chronic pain.
D) Waiting until the client complains of pain makes pain relief more difficult and increases anxiety.
Page Ref: 726
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 10.A. Analyze appendicitis as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with appendicitis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with appendicitis.

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7) The nurse is caring for a client in the emergency department who is suspected of having appendicitis. Which orders should the nurse anticipate from the healthcare provider? **Select all that apply.**
A) A cephalosporin antibiotic
B) A barium enema
C) Regular diet
D) Pain medication
E) Complete white blood cell count
Answer: A, D, E
Explanation: A) A cephalosporin, a third-generation antibiotic is the antibiotics of choice for appendicitis. The client should take nothing by mouth, so a regular diet is contraindicated.
B) A barium enema would not be ordered, as this could cause perforation of the appendix and bowel.
C) The client should take nothing by mouth, so a regular diet is contraindicated.
D) Pain medications will be ordered.
E) The provider will order a complete white blood cell count, which will be elevated if the client has appendicitis.
Page Ref: 723-724
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
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Learning Outcome: 10.A. Analyze appendicitis as it relates to inflammation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with appendicitis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with appendicitis.

8) The nurse is conducting an assessment on a client who is 36 hours postoperative following an appendectomy. During the assessment, the nurse is unable to hear any bowel sounds. The client denies passing flatus. Which action should the nurse take?
A) Assist with ambulation.
B) Encourage the client to increase oral fluid intake to promote peristalsis.
C) Encourage the client to increase solid food intake to promote peristalsis.
D) Encourage the client to decrease the amount of oral food and fluid intake.
Answer: A
Explanation: A) After abdominal surgery, the risk of a paralytic ileus exists. An ileus results when the bowel is not experiencing peristalsis. Ambulation can help expel intestinal gas and aid in the return of normal peristalsis.
B) Oral fluids will not promote peristalsis.
C) Eating will not promote peristalsis.
D) The client is likely to be taking nothing by mouth so reducing the amount of food and oral fluids would not be applicable.
Page Ref: 726
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.A. Analyze appendicitis as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with appendicitis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with appendicitis.

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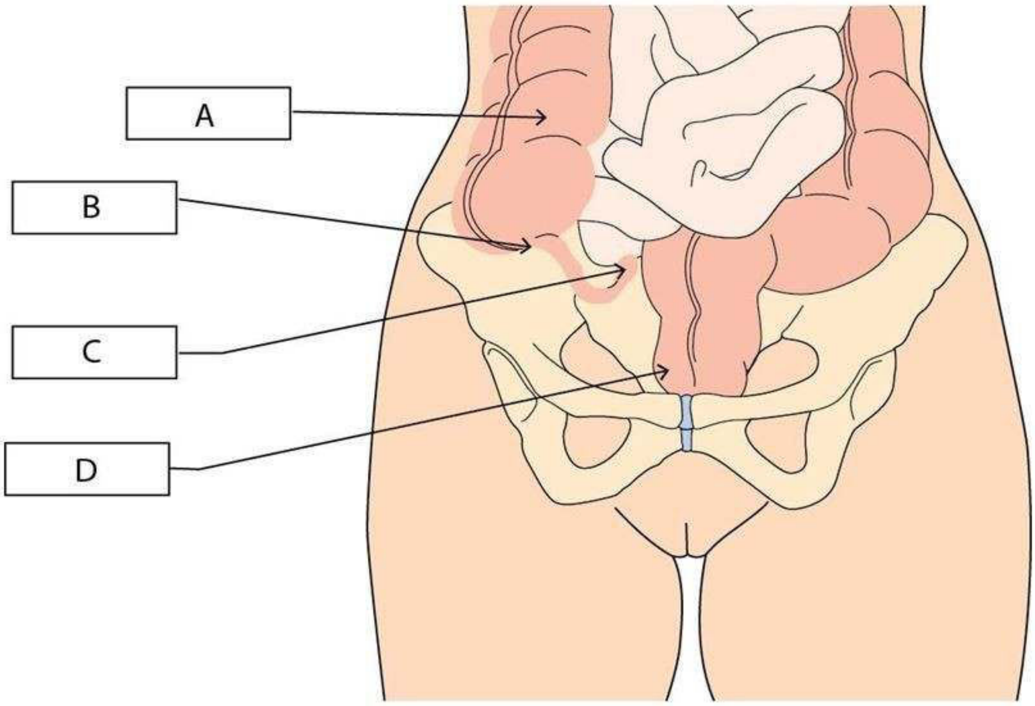

The nurse checking for tenderness at McBurney point for a client with suspected appendicitis will palpate which area?

A) A
B) B
C) C
D) D
Answer: B
Explanation: A) McBurney point is not located near the liver.
B) McBurney point, located midway between the umbilicus and the anterior iliac crest in the right lower quadrant, is the usual site for localized pain and rebound tenderness due to appendicitis.
C) McBurney point is not located at the site of the appendix.
D) McBurney point is not located at the site of the rectum.
Page Ref: 722
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 10.A. Analyze appendicitis as it relates to inflammation. Identify the clinical manifestations of appendicitis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with appendicitis.

10) In which order will the nurse list the pathophysiologic processes involved in appendicitis?
A) The appendix becomes distended with fluid secreted by its mucosa.
B) The proximal lumen of the appendix becomes obstructed.
C) Purulent exudate forms and causes further distention of the appendix.
D) Pressure within the lumen of the appendix increases.
E) Tissue necrosis occurs and gangrene develops.
Answer: B, A, D, C, E
Explanation: Obstruction of the proximal lumen of the appendix is apparent in most acutely inflamed appendices. Following obstruction, the appendix becomes distended with fluid secreted by its mucosa. Pressure within the lumen of the appendix increases, impairs its blood supply, and leads to inflammation, edema, ulceration, and infection. The purulent exudate formed causes further distention of the appendix. If treatment is not initiated, tissue necrosis and gangrene result within 24-36 hours, leading to perforation (rupture).
Page Ref: 722
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.A. Analyze appendicitis as it relates to inflammation. Describe the pathophysiology of appendicitis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with appendicitis.

11) For which reason is laparotomy typically the surgery of choice for a perforated appendix?

A) Surgeons are better able to remove contaminants from the peritoneal cavity via laparotomy than via laparoscopy.

B) Laparotomy requires a smaller incision than laparoscopy and thus involves less blood loss.

C) Laparotomy involves a shorter period of postoperative hospitalization than laparoscopy.

D) Laparotomy allows for direct visualization of the damaged appendix, whereas laparoscopy does not.

Answer: A

Explanation: A) When a client's appendix has burst, laparotomy is usually the procedure of choice, because it allows for removal of contaminants from the peritoneal cavity by irrigation with sterile normal saline.

B) A laparotomy does not have a smaller incision than laparoscopy.

C) Recovery from a laparotomy will be longer.

D) Laparoscopy allows for direct visualization of the appendix without the need for open abdominal surgery, requires a shorter postoperative hospital stay, carries a lower risk of postoperative complications, and allows for more rapid recovery and resumption of normal activities.

Page Ref: 724

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 10.A. Analyze appendicitis as it relates to inflammation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with appendicitis.

MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with appendicitis.

12) A nurse who works in an extended care facility is planning a staff teaching session regarding the care of older adult clients with appendicitis. Which points would be most appropriate for the nurse to include in the lesson plan?
A) "Almost all older clients with appendicitis present with a moderate to high fever."
B) "In older adults, the pain associated with appendicitis tends to fall closer to the midline than to McBurney point."
C) "Older adults with appendicitis rarely present with confusion, although they may be agitated due to severe abdominal pain."
D) "About half of older adult clients with appendicitis do not demonstrate rebound or involuntary guarding."
Answer: D
Explanation: A) Because of decreased function in the immune system, older adults can have a diminished inflammatory response and may not present with the classical signs of appendicitis.
B) When abdominal pain is present in older adults, it is located near McBurney point, not along the midline.
C) Older adults are likely to present with confusion.
D) When older adults present with abdominal pain, appendicitis should be considered.
Page Ref: 725
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 10.A. Analyze appendicitis as it relates to inflammation. Differentiate care of patients with appendicitis across the lifespan.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with appendicitis.

Exemplar 10.B Gallbladder Disease

1) The nurse is caring for a client who was admitted to the hospital 1 day prior with cholelithiasis. Which new assessment finding indicates that the stone has probably obstructed the client's common bile duct?
A) Nausea and vomiting
B) Jaundice
C) Right upper quadrant (RUQ) pain
D) Elevated cholesterol level
Answer: B
Explanation: A) Nausea and vomiting occurs in cystic duct disease.
B) Obstruction of the common bile duct results in reflux of bile into the liver, which produces jaundice.
C) RUQ pain occurs in cystic duct disease.
D) Cholesterol levels do not increase with biliary obstruction.
Page Ref: 728
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.B. Analyze gallbladder disease as it relates to inflammation. Describe the pathophysiology of gallbladder disease.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with gallbladder disease.

2) The nurse is caring for an older adult client with gallbladder disease who is recovering from a cholecystectomy. Which risk factors increase this client's susceptibility to infection? **Select all that apply.**

A) Dry skin

B) Advanced age

C) Intact mucous membranes

D) Nonintact skin

E) Active bowel sounds

Answer: B, D

Explanation: A) Dry skin is a factor that helps defend the body against infection.

B) This client is more susceptible to infection due to advanced age.

C) Having intact mucous membranes is a factor that helps defend the body against infection.

D) This client is more susceptible to infection due to the presence of a surgical incision. A surgical incision indicates that the body's first line of defense, the skin, is not intact.

E) Active bowel sounds have no effect on immunity or susceptibility to developing an infection.

Page Ref: 731-732

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 10.B. Analyze gallbladder disease as it relates to inflammation. Differentiate care of patients with gallbladder disease across the lifespan.

MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with gallbladder disease.

3) The nurse educator in a gastrostomy clinic is teaching a group of clients about factors that play a role in the formation of gallstones. Which client would the nurse identify as having the highest risk for gallstone formation due to genetic factors?

A) A client with sickle cell disease
B) A client with a family history of Huntington chorea
C) A client whose father had Alzheimer disease
D) A client with the ABCG5/G8 genetic marker

Answer: D

Explanation: A) Sickle cell disease does not predispose a client to developing gallstones.
B) A family history of Huntington chorea does not predispose the development of gallstones.
C) Alzheimer disease is not a predictive marker for the development of gallstones.
D) There are known genetic factors/variants that predispose carriers for gallbladder disease. Variants of hepatic and intestinal cholesterol transporter ABCG5/G8 are the most common.

Page Ref: 729

Cognitive Level: Analyzing

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 10.B. Analyze gallbladder disease as it relates to inflammation. Compare the risk factors and prevention of gallbladder disease.

MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with gallbladder disease.

4) The nurse is caring for an older adult client with cholecystitis. The client has been admitted to the hospital for diagnostic testing and pain control. Which problem would be of highest priority for this client?
A) Anxiety
B) Potential for infection
C) Chronic pain
D) Inability to provide self-care
Answer: B
Explanation: A) There is no evidence that an older client will have a problem with anxiety because of the condition.
B) Because older adults do not have as effective an immune system as younger clients, the problem of a potential for infection would be the priority.
C) The client will most likely experience acute pain and not chronic pain.
D) There is no evidence that the client will not be able to participate in self-care.
Page Ref: 732
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosing

Learning Outcome: 10.B. Analyze gallbladder disease as it relates to inflammation. Differentiate care of patients with gallbladder disease across the lifespan.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with gallbladder disease.

5) A client who is 4 days post-cholecystectomy has T-tube drainage totaling 600 mL in 24 hours. Which actions by the nurse are appropriate at this time? **Select all that apply.**
A) Notify the healthcare provider.
B) Place the client in a supine position.
C) Assess drainage characteristics.
D) Clamp the tube q 2 hours for 30 minutes.
E) Encourage increased fluid intake.
Answer: A, C
Explanation: A) The T-tube may drain 500 mL in the first 24 hours and is expected to decrease steadily thereafter. If there is excessive drainage, as in this scenario, the nurse should further assess the drainage to be able to describe it accurately and notify the healthcare provider immediately.
B) Placing the client in a supine position would not be beneficial.
C) The T-tube may drain 500 mL in the first 24 hours and is expected to decrease steadily thereafter. If there is excessive drainage, as in this scenario, the nurse should further assess the drainage to be able to describe it accurately.
D) Clamping the tube would be contraindicated.
E) Encouraging fluids would not be beneficial.
Page Ref: 733
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.B. Analyze gallbladder disease as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with gallbladder disease.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with gallbladder disease.

6) The nurse is evaluating care provided to an older adult client with a history of cholecystitis 5 months ago. Which statement indicates that the client met a goal in the plan of care?

A) "I have increased my intake of fat."
B) "I have been eating out often."
C) "I have been walking 1 mile every day."
D) "I have been able to gain 5 pounds on the new diet."

Answer: D

Explanation: A) The client would want to decrease fat intake.
B) Eating out would not be a goal for a client being treated for cholecystitis.
C) Exercise is excellent but does not directly support actions related to cholecystitis.
D) The older adult client with cholecystitis is at elevated risk for infection. Thus, a goal would be to stabilize or increase weight through appropriate dietary measures to support the client's immune system and resist infection.

Page Ref: 733

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 10.B. Analyze gallbladder disease as it relates to inflammation. Differentiate care of patients with gallbladder disease across the lifespan.

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MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with gallbladder disease.

7) Which lifestyle change would most likely increase a client's risk for cholelithiasis?
A) Reducing intake of high-fat foods
B) Increasing intake of high-cholesterol foods
C) Beginning a regular exercise routine
D) Discontinuing use of hormonal birth control
Answer: B
Explanation: A) Reducing high-fat foods would reduce the risk for cholelithiasis.
B) Several factors increase a client's risk for gallbladder disease, including consuming foods that are high in fat and cholesterol.
C) Exercise can aid in weight control, thereby reducing a client's risk for gallbladder disease.
D) Eliminating the use of hormonal birth control will reduce the risk for cholelithiasis.
Page Ref: 729
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.B. Analyze gallbladder disease as it relates to inflammation. Compare the risk factors and prevention of gallbladder disease.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with gallbladder disease.

8) A client with cholelithiasis is in the clinic for a follow-up assessment after hospitalization. Which lifestyle modification should the nurse teach the client to decrease the pain associated with the disease process?
A) Reduce sodium intake.
B) Decrease fat consumption.
C) Increase fluids.
D) Decrease smoking.
Answer: B
Explanation: A) Although all clients should be instructed to reduce sodium intake, decreasing sodium will not assist in reducing cholelithiasis or its pain.
B) A client who is experiencing cholelithiasis should be instructed on the relationship between increased fat consumption and the severity of pain associated with cholelithiasis.
C) Increasing fluids will not assist in reducing cholelithiasis or its pain.
D) While all clients should be encouraged to cease smoking, smoking has no relationship to cholelithiasis.
Page Ref: 729
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.B. Analyze gallbladder disease as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with gallbladder disease.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with gallbladder disease.

9) The nurse is caring for a client with severe acute abdominal pain secondary to cholelithiasis. Which nursing actions promote effective pain management? **Select all that apply.**

A) Withhold oral food and fluids.

B) Insert nasogastric tube and connect to high suction.

C) Educate the client about decreasing protein in the diet, because protein increases gallbladder contractions.

D) Administer morphine, meperidine, or another opioid analgesic as ordered.

E) Place the patient in supine position to relieve abdominal pain.

Answer: A, D

Explanation: A) The pain associated with cholelithiasis can be severe. Nursing interventions that help promote effective pain management include withholding oral food and fluids.

B) Nursing interventions that help promote effective pain management include inserting a nasogastric tube connected to low suction if ordered.

C) The nurse should educate the client about decreasing fat in the diet, because fat entering the duodenum initiates gallbladder contractions, causing pain when gallstones are in the ducts.

D) Administering morphine or another opioid analgesic as ordered also aids in pain management.

E) The nurse should place the patient in Fowler position, not supine, to decrease pressure on the inflamed gallbladder.

Page Ref: 732-733

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 10.B. Analyze gallbladder disease as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with gallbladder disease.

MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with gallbladder disease.

10) Which medication is used to reduce the cholesterol content of gallstones and lead to their gradual dissolution?
A) Cholestyramine
B) Chenodiol
C) Meperidine
D) Amoxicillin
Answer: B
Explanation: A) Cholestyramine (Questran) is administered to relieve jaundice and pruritus related to accumulation of bile salts on the skin.
B) Chenodiol (Chenix) is administered to reduce the cholesterol content of gallstones and lead to their gradual dissolution. This drug acts by reducing cholesterol production in the liver, thus reducing the cholesterol content of bile.
C) Because of all the different metabolites, toxicity, and poor pain control, meperidine is not recommended as an analgesic unless the patient is allergic to all other opioids.
D) Amoxicillin is given to reduce the likelihood of infection.
Page Ref: 733
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.B. Analyze gallbladder disease as it relates to inflammation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a gallbladder disease.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with gallbladder disease.

11) Which laboratory result suggests that a client with gallbladder disease is experiencing obstructed bile flow in the biliary duct system?

A) Decreased WBC count

B) Elevated WBC count

C) Decreased direct bilirubin

D) Elevated direct bilirubin

Answer: D

Explanation: A) Clients with gallbladder disease often have an elevated WBC count.

B) Although clients with gallbladder disease often have an elevated WBC count, this result is suggestive of infection and inflammation rather than obstructed bile flow.

C) In clients with gallbladder disease, the direct bilirubin level will not be decreased.

D) In clients with gallbladder disease, elevated direct bilirubin may indicate obstructed bile flow in the biliary duct system.

Page Ref: 730

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | | Nursing Process: Assessment

Learning Outcome: 10.B. Analyze gallbladder disease as it relates to inflammation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a gallbladder disease.

MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with gallbladder disease.

Exemplar 10.C Inflammatory Bowel Disease

1) An adolescent client is experiencing abdominal pain with diarrhea and bloody stools. Which type of inflammatory bowel disease does the nurse suspect the client is experiencing?
A) Appendicitis
B) Ulcerative colitis
C) Crohn disease
D) Necrotizing enterocolitis
Answer: B
Explanation:
A) Appendicitis is not associated with bloody stools, and usually not with diarrhea.
B) Diarrhea and bloody stools are typical symptoms of ulcerative colitis.
C) An adolescent with Crohn disease might have abdominal pain and diarrhea, but stools usually do not have blood in them.
D) Necrotizing enterocolitis is usually seen in premature infants and not generally in adolescent clients.
Page Ref: 737
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.C. Analyze inflammatory bowel disease (IBD) as it relates to inflammation. Identify the clinical manifestations of IBD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with inflammatory bowel disease.

2) The nurse is caring for an adolescent client who has been nonadherent to the medical plan of care to treat Crohn disease. In order to increase adherent behavior, which complication associated with Crohn disease should the nurse include in the client's teaching plan?
A) Vomiting
B) Bowel perforation
C) Intestinal obstruction
D) Diarrhea
Answer: B
Explanation: A) Vomiting is a common symptom of Crohn disease and may occur even if the client is compliant with the medical plan of care.
B) Bowel perforation is rare but may be a consequence of noncompliance with the treatment plan, because the client's disease would continue to progress.
C) Intestinal obstruction is a common symptom of Crohn disease and may occur even if the client is compliant with the medical plan of care.
D) Diarrhea is a common symptom of Crohn disease and may occur even if the client is compliant with the medical plan of care.
Page Ref: 740
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 10.C. Analyze inflammatory bowel disease (IBD) as it relates to inflammation. Identify the clinical manifestations of IBD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with inflammatory bowel disease.

3) Which statement is true about ulcerative colitis and Crohn disease?
A) Clients with ulcerative colitis experience periods of remission, whereas clients with Crohn disease do not.
B) Ulcerative colitis is limited to the colon and rectum, whereas Crohn disease can affect any part of the GI tract.
C) The inflammatory lesions associated with Crohn disease are continuous, whereas those associated with ulcerative colitis are not.
D) Ulcerative colitis is more common in women, whereas Crohn disease is more common in men.
Answer: B
Explanation: A) Ulcerative colitis and Crohn disease are chronic diseases with periods of remission and active disease.
B) Ulcerative colitis is limited to the colon and rectum, whereas Crohn disease can affect any part of the GI tract from mouth to anus.
C) Ulcerative colitis involves continuous lesions, whereas Crohn disease is marked by patchy or "skip" lesions.
D) Ulcerative colitis and Crohn disease affect both genders equally.
Page Ref: 735
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.C. Analyze inflammatory bowel disease (IBD) as it relates to inflammation. Identify the clinical manifestations of IBD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with inflammatory bowel disease.

4) The nurse provides teaching related to the problem of risk for fluid volume deficit to a client with ulcerative colitis. Which statement on the part of the client indicates that this teaching has been effective?
A) "I will drink at least 2 quarts of fluid each day."
B) "I will continue to use a moisturizer on my skin."
C) "I should report dry patches of skin immediately to my doctor."
D) "If I have two liquid stools in any day, I will report this to my healthcare provider."
Answer: A
Explanation: A) The client with irritable bowel syndrome should be taught to maintain a higher-than-normal fluid intake to maintain hydration.
B) Moisturizing the skin is a positive action for this client but does not indicate appropriate understanding of the teaching that is appropriate for this problem.
C) The client's dry patches could be due to a fluid volume deficit but would not necessitate immediate notification.
D) Two liquid stools a day is not excessive for a client with ulcerative colitis, but the client must remember to take in enough fluid to account for these stools as well as the normal fluid needs of the body.
Page Ref: 745
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 10.C. Analyze inflammatory bowel disease (IBD) as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with IBD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with inflammatory bowel disease.

5) Which condition is the leading indication for surgery in Crohn disease?
A) Bowel obstruction
B) Internal fistula
C) Perianal complications
D) Abscess
Answer: A
Explanation: A) Bowel obstruction is the leading indication for surgery in Crohn disease.
B) Other complications that less commonly require surgical intervention include an internal fistula.
C) Other complications that less commonly require surgical intervention include perianal complications.
D) Other complications that less commonly require surgical intervention include an abscess.
Page Ref: 741
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 10.C. Analyze inflammatory bowel disease (IBD) as it relates to inflammation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with IBD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with inflammatory bowel disease.

6) A home health nurse is evaluating a client who had a colostomy placed 6 weeks ago for the treatment of ulcerative colitis. Which assessment would cause the nurse to conclude that teaching goals for this client have been met?
A) The client's colostomy pouch is clean and dry.
B) The client's vital signs reveal a normal temperature.
C) The client's stoma is pink and intact.
D) The client experiences pain with certain types of food.
Answer: C
Explanation: A) It is not as critical that the ostomy pouch be clean and dry, particularly if the client has passed a stool.
B) A normal temperature would not be a particular goal for a client 6 weeks postoperatively.
C) Stoma care is taught to the client after surgery, and the goal is for the stoma to be pink with intact skin.
D) Patients with ulcerative colitis are going to have pain when they eat foods that irritate the bowel, but this is not a goal.
Page Ref: 741
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 10.C. Analyze inflammatory bowel disease (IBD) as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with IBD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with inflammatory bowel disease.

7) A client is being scheduled for diagnostic tests to determine the presence of ulcerative colitis. For which diagnostic tests should the nurse plan to provide teaching? **Select all that apply.**
A) Barium enema
B) Intravenous pyelogram
C) Colonoscopy
D) Upper endoscopy
E) Barium swallow
Answer: A, C, E
Explanation: A) Tests to diagnose ulcerative colitis include a barium enema.
B) An intravenous pyelogram is used to diagnose kidney disorders.
C) Tests to diagnose ulcerative colitis include a colonoscopy.
D) An upper endoscopy is used to diagnose disorders of the esophagus and stomach.
E) Tests to diagnose ulcerative colitis include a barium swallow.
Page Ref: 740
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 10.C.2. Analyze inflammatory bowel disease (IBD) as it relates to inflammation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with IBD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with inflammatory bowel disease.

8) The nurse is receiving a client from the emergency department who was diagnosed with an acute exacerbation of ulcerative colitis. The nurse anticipates that the client may present with which clinical characteristics? **Select all that apply.**
A) More than 6 diarrhea stools per day with blood and mucus
B) Steady right lower quadrant or periumbilical pain
C) Cramping in the left lower quadrant that is relieved by defecation
D) Tenderness and a mass in the right lower quadrant
E) Fever, malaise, and fatigue
Answer: A, C
Explanation: A) With severe ulcerative colitis, the client may have more than 6 diarrhea stools per day with blood and mucus.
B) A client with Crohn disease will experience steady right lower quadrant or periumbilical pain.
C) The pain associated with ulcerative colitis presents with cramping in the left lower quadrant which is relieved by defecation.
D) Tenderness and a mass in the right lower quadrant are characteristics of Crohn disease.
E) Fever, malaise, and fatigue are characteristics of Crohn disease.
Page Ref: 737
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.C. Analyze inflammatory bowel disease (IBD) as it relates to inflammation. Identify the clinical manifestations of IBD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with inflammatory bowel disease.

9) The nurse is caring for a pediatric client with inflammatory bowel disease (IBD). Which symptoms should the nurse expect to assess in this client when compared to an adult with the same condition? **Select all that apply.**
A) More frequent symptoms of Crohn disease than ulcerative colitis
B) Development of fistulas or strictures
C) Colonic involvement
D) Left-sided colitis
E) More common in females than males
Answer: A, C
Explanation: A) Children suffer from Crohn disease more frequently than ulcerative colitis.
B) Children with Crohn disease usually present with inflammatory disease; adults often present with fistulizing or stricturing disease.
C) The majority of pediatric clients have ileocolonic or colonic disease.
D) Children with ulcerative colitis usually present with pancolitis, whereas adults more often present with left-sided colitis.
E) IBD is more common in males than females in the pediatric population.
Page Ref: 742
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 10.C. Analyze inflammatory bowel disease (IBD) as it relates to inflammation. Differentiate care of patients with IBD across the lifespan.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with inflammatory bowel disease.

Exemplar 10.D Nephritis

1) The nurse is caring for a client newly admitted to the medical-surgical unit with glomerulonephritis. Which classic manifestations of this disorder should the nurse expect to assess in this client? **Select all that apply.**
A) Edema
B) Weight loss
C) Hematuria
D) Acute flank pain
E) Proteinuria
Answer: A, C, D, E
Explanation: A) As the disease progresses, there will be an increase in edema, especially in the lower legs and ankles during the daytime.
B) Weight loss is a nonspecific symptom that can occur with many disorders, but not typically with glomerulonephritis.
C) Hematuria is a classic sign of glomerulonephritis.
D) Flank pain can develop abruptly in glomerulonephritis.
E) Proteinuria is a classic sign of glomerulonephritis.
Page Ref: 750
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.D. Analyze nephritis as it relates to inflammation. Identify the clinical manifestations of nephritis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with nephritis.

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2) The nurse conducts an evaluation after completing a training session for community members on ways to prevent nephritis. When evaluating the success of this session, what responses from the community members would indicate that learning has been successful? **Select all that apply.**

A) "Practicing good hygiene can help prevent nephritis."
B) "One way to help avoid nephritis is by not smoking."
C) "Maintaining a healthy body weight helps promote kidney health."
D) "I should limit my alcohol intake to reduce the risk of nephritis."
E) "Controlling high blood pressure is important in the prevention of nephritis."

Answer: A, B, C, E

Explanation: A) The exact cause of nephritis is unknown but preventing viral infections through practicing good hygiene habits reduces the risk of developing this disease.
B) The exact cause of nephritis is unknown, but not smoking reduces the risk of developing this disease.
C) The exact cause of nephritis is unknown but maintaining a healthy body weight reduces the risk of developing this disease.
D) Limiting alcohol intake will not affect the development of nephritis.
E) The exact cause of nephritis is unknown but controlling high blood pressure reduces the risk of developing this disease.

Page Ref: 750
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

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Learning Outcome: 10.D. Analyze nephritis as it relates to inflammation. Compare the risk factors and prevention of nephritis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with nephritis.

3) The nurse is caring for a Black client with nephritis. When planning this client's care, the nurse should include interventions aimed at preventing which of the following long-term complications?
A) Congestive heart failure
B) Diabetes mellitus
C) End-stage renal disease
D) Hypertension
Answer: C
Explanation: A) Black clients are not at increased risk of developing congestive heart failure after nephritis.
B) Black clients are not at increased risk of developing diabetes mellitus after nephritis.
C) Black clients have an increased risk of progressing to end-stage renal disease after nephritis.
D) Black clients are not at increased risk of developing hypertension after nephritis.
Page Ref: 750
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 10.D. Analyze nephritis as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with nephritis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with nephritis.

4) The nurse has identified the problem of fluid volume excess as appropriate for a client with acute glomerulonephritis. Which parameter should the nurse assess to obtain the most accurate indication of this client's fluid balance?
A) Vital signs
B) Intake and output records
C) Daily weight
D) Serum sodium levels
Answer: C
Explanation: A) Vital signs will provide data about fluid balance; however, they will not provide the most accurate information.
B) Intake and output records will all provide data indicating fluid balance; however, it is not as accurate as daily weight for determining fluid balance.
C) Daily weight provides the most accurate indication of fluid balance because of the pathophysiology of acute glomerulonephritis.
D) Serum sodium levels will all provide data indicating fluid balance; however, they are not as accurate as daily weight for determining fluid balance.
Page Ref: 754
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 10.D. Analyze nephritis as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with nephritis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with nephritis.

5) A client being discharged after treatment for nephritis is concerned about having adequate stamina to care for the family after discharge. Which statement made by the nurse would be most appropriate to address the client's concern?

A) "Tell your spouse help is needed."
B) "You will be able to keep up with your family's needs once you return home."
C) "It sounds like you need some help, so I'll contact Social Services for support."
D) "Maybe your children should stay with a relative or neighbor for a few weeks."

Answer: C

Explanation: A) The nurse should not assume that the client has a spouse.
B) The client will be easily fatigued and will need assistance after treatment for nephritis.
C) The nurse should contact Social Services to obtain support for the client.
D) The client might not have family nearby or neighbors who are available to care for the children for a few weeks.

Page Ref: 754

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 10.D. Analyze nephritis as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with nephritis.

MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with nephritis.

6) A client is experiencing weight gain and foamy dark urine 4 weeks after being treated with antibiotics for a sore throat. Which client statement, made during the health history assessment, suggests that the nurse should provide the client with further instruction?
A) "I've been trying to get plenty of rest since I've been sick."
B) "I've started eating a more nutritious diet."
C) "I felt better after 1 week of the antibiotics, so I stopped taking them."
D) "I've gained a bit of weight over the last 2 weeks."
Answer: C
Explanation: A) Resting when ill is appropriate.
B) Eating a more nutritious diet is appropriate.
C) The client probably had strep throat and did not take the full course of antibiotics, which accounts for the current symptoms that indicate glomerulonephritis.
D) Gaining weight would support the nurse's suspicion that the client has glomerulonephritis.
Page Ref: 753
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 10.D. Analyze nephritis as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with nephritis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with nephritis.

7) A client being treated for nephrotic syndrome is a vegetarian and has recently experienced poor oral intake. Which action should the nurse take to meet this client's nutritional needs?
A) Request that the healthcare provider prescribe an appetite stimulant.
B) Request that a dietitian discuss dietary preferences with the client.
C) Encourage the client to eat the food provided on the meal trays.
D) Explain that the client will be returning home soon and can resume a preferred diet.
Answer: B
Explanation: A) An appetite stimulant is not going to improve the client's appetite if foods are provided that the client does not eat.
B) The client is being treated for nephrotic syndrome, which could impact the amount of protein permitted to be eaten each day. The client should discuss dietary preferences with a dietitian so that the client's nutritional needs will be met.
C) The nurse should not encourage the client to eat foods that do not support the client's vegetarian diet.
D) The nurse needs to help the client now and not have the client wait to go to home before having foods that the client wants to eat.
Page Ref: 754
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.D. Analyze nephritis as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with nephritis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with nephritis.

8) A child who is hospitalized with acute glomerulonephritis experiences blurred vision and headache while in the playroom. Which action by the nurse is the most appropriate?
A) Reassure the child and encourage bed rest until the headache improves.
B) Obtain the child's blood pressure and notify the physician.
C) Check the child's urine to see if hematuria has increased.
D) Obtain the child's serum electrolytes and send a urinalysis to the lab.
Answer: B
Explanation: A) Encouraging bed rest does not directly address the potential problem of encephalopathy.
B) Blurred vision and headache may be signs of encephalopathy, a complication of acute glomerulonephritis. The nurse should obtain a blood pressure reading and notify the physician.
C) Checking urine for hematuria does not directly address the potential problem of encephalopathy.
D) Obtaining serum electrolytes and a urine specimen do not directly address the potential problem of encephalopathy.
Page Ref: 753
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.D. Analyze nephritis as it relates to inflammation. Differentiate care of patients with nephritis across the lifespan.

MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with nephritis.

9) The nurse is assessing an older adult client with suspected acute interstitial nephritis. When gathering this client's health history, the nurse should be sure to ask the client which question?
A) "When is the last time you had a urinalysis?"
B) "Are you taking any medications for the treatment of indigestion?"
C) "Do you take any ACE inhibitors?"
D) "How much protein do you eat on an average day?"
Answer: B
Explanation: A) Although the client will require urinalysis, the timing of the client's last urine test is not important.
B) The nurse should inquire whether the client is taking any medications for the treatment of indigestion, because many cases of acute interstitial nephritis in older adults are due to use of proton pump inhibitors.
C) Angiotensin-converting enzyme (ACE) inhibitors do not contribute to a client's likelihood of acute interstitial nephritis.
D) Protein intake is unrelated to this diagnosis.
Page Ref: 712
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.D. Analyze nephritis as it relates to inflammation. Differentiate care of patients with nephritis across the lifespan.

MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with nephritis.

10) Which diagnostic procedure for glomerular disorders is essential and the most reliable?
A) Kidney scan
B) KUB abdominal x-ray
C) ASO titer
D) Biopsy
Answer: D
Explanation: A) A kidney scan allows visualization of the kidney after IV administration of a radioisotope, but the results are not as definitive as with a biopsy.
B) A KUB (kidney, ureter, bladder) abdominal x-ray may be done to evaluate kidney size and to rule out other causes of the patient's manifestations, but not to definitively diagnose glomerular disorders.
C) ASO titers and similar blood tests detect streptococcal exoenzymes that stimulate the immune response in acute postinfection glomerulonephritis, but they cannot provide a clear diagnosis of glomerular dysfunction.
D) A biopsy is the essential and most reliable diagnostic procedure for glomerular disorders. A biopsy helps determine the type of nephritis, the prognosis, and the appropriate treatment.
Page Ref: 751
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.D. Analyze nephritis as it relates to inflammation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with nephritis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with nephritis.

11) Which laboratory value increases in the presence of renal impairment?
A) Creatinine clearance
B) Urine creatinine
C) Serum creatinine
D) Total urine output
Answer: C
Explanation: A) Creatinine clearance decreases in the presence of renal impairment.
B) Urine creatinine decreases in the presence of renal impairment.
C) Serum creatinine is excreted entirely by the kidneys, making it a good indicator of kidney function. Elevations in serum creatinine levels indicate impairment of renal function.
D) Total urine output decreases in the presence of renal impairment.
Page Ref: 751
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.D. Analyze nephritis as it relates to inflammation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with nephritis.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with nephritis.

Exemplar 10.E Peptic Ulcer Disease

1) A client is being treated with blood transfusions for a large peptic ulcer in the duodenum. Which information in the client's history should the nurse suspect as a potential cause of this health problem?
A) Allergies to penicillin and morphine sulfate
B) History of chronic atrial fibrillation
C) Daily medications include naproxen sodium and aspirin
D) History of recent cataract extraction with lens implant
Answer: C
Explanation: A) Allergies to penicillin and morphine sulfate are not relevant to the client's bleeding incident.
B) History of atrial fibrillation is not relevant to the client's bleeding incident.
C) Clients who are taking high doses of nonsteroidal anti-inflammatory agents (NSAIDs) such as naproxen sodium and aspirin are predisposed to developing large ulcers that do not cause pain. The first symptom the client often experiences is a significant bleeding episode. Concurrent use of NSAIDs and aspirin should, therefore be, avoided.
D) Recent eye surgery is not relevant to the client's bleeding incident.
Page Ref: 757
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.E. Analyze peptic ulcer disease (PUD) as it relates to inflammation. Compare the risk factors and prevention of PUD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with peptic ulcer disease.

2) The nurse is planning a teaching session for older community members about the risks for peptic ulcer disease (PUD) in this age group. Which information should the nurse include when teaching this group?
A) PUD causes less bleeding in older clients than in younger clients.
B) Older clients experience more severe abdominal pain than younger clients with PUD.
C) Older clients should undergo colonoscopy when diagnosed with PUD.
D) PUD is likely exacerbated by the bacterium *Helicobacter pylori* (*H. pylori*).
Answer: D
Explanation: A) There is no evidence that PUD causes less bleeding in older clients.
B) There is no evidence that older clients experience more severe abdominal pain with PUD.
C) Clients with peptic ulcers should have upper GI endoscopy performed to diagnose the problem with visualization and biopsy, not colonoscopy.
D) *H. pylori* infection is a major factor in the development of ulcers, and prevalence increases with the age of the client.
Page Ref: 760
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 10.E. Analyze peptic ulcer disease (PUD) as it relates to inflammation. Differentiate care of patients with PUD across the lifespan.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with peptic ulcer disease.

3) The healthcare provider prescribes misoprostol (Cytotec) for a female client for the treatment of peptic ulcer disease. Which question should the nurse ask the client prior to administration of this medication?
A) "Is there any chance that you are pregnant?"
B) "Are you currently sexually active?"
C) "Are your menstrual cycles irregular?"
D) "Do you plan on becoming pregnant in the next few months?"
Answer: A
Explanation: A) Misoprostol (Cytotec) is contraindicated during pregnancy.
B) Asking if client is sexually active could be appropriate, but the nurse would also ask if the client is using birth control.
C) There is no contraindication for misoprostol (Cytotec) in a client with irregular menstrual cycles.
D) Misoprostol (Cytotec) is safe as long as the client is not pregnant.
Page Ref: 760
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 10.E. Analyze peptic ulcer disease (PUD) as it relates to inflammation. Differentiate care of patients with PUD across the lifespan.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with peptic ulcer disease.

4) The nurse is caring for a client who receives H_2-receptor antagonists for the treatment of peptic ulcer disease. Based on the problem of bleeding, which assessment finding should the nurse report immediately to the healthcare provider?
A) The client reports pain after 24 hours of treatment.
B) The client reports episodes of melena.
C) The client reports constipation.
D) The client reports taking Tums antacids with his H_2-receptor antagonist.
Answer: B
Explanation: A) The client may still experience pain for several days with this type of medication.
B) Melena could indicate GI bleeding and should be reported to the physician immediately.
C) Constipation is a common side effect that does not need to be immediately reported to the healthcare provider.
D) Taking Tums antacids with an H_2-receptor antagonist will cause decreased absorption of the H_2-receptor antagonist, but this does not need to be reported to the healthcare provider; rather, the nurse should educate the client.
Page Ref: 761
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 10.E. Analyze peptic ulcer disease (PUD) as it relates to inflammation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with PUD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with peptic ulcer disease.

5) Which drug used in the treatment of peptic ulcer disease (PUD) works by both binding to proteins in the ulcer base and stimulating the secretion of mucus?
A) Sucralfate
B) Omeprazole
C) Misoprostol
D) Bismuth
Answer: A
Explanation: A) All of the medications listed can be used to treat PUD, but they work in different ways. Sucralfate binds to proteins in the ulcer base, forming a protective barrier against acid, bile, and pepsin. Sucralfate also stimulates the secretion of mucus, bicarbonate, and prostaglandin.
B) Omeprazole is a proton-pump inhibitor (PPI).
C) Misoprostol promotes ulcer healing by stimulating mucus and bicarbonate secretions and inhibiting acid secretion.
D) Bismuth compounds stimulate mucosal bicarbonate and prostaglandin production to promote ulcer healing and suppress *Helicobacter pylori*.
Page Ref: 760
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.E.3. Analyze peptic ulcer disease (PUD) as it relates to inflammation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with PUD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with peptic ulcer disease.

6) The nurse provides discharge teaching for a client with peptic ulcer disease (PUD). Which client statement indicates that teaching has been effective?
A) "I will drink more milk and limit spicy foods."
B) "I will take ibuprofen (Motrin) for my headaches."
C) "I am taking smoking cessation classes."
D) "I will join a gym and increase my exercise."
Answer: C
Explanation: A) Diet is usually not a major factor in the development of peptic ulcers, so eating or avoiding specific foods is not currently encouraged for the treatment of PUD.
B) Nonsteroidal anti-inflammatory drugs (NSAIDs) like Motrin should be avoided because they are a primary cause of PUD.
C) Cigarette smoking inhibits the secretion of bicarbonate by the pancreas and may cause more rapid transit of gastric acid into the duodenum leading to the development of PUD.
D) There is no correlation between exercise and the management of PUD.
Page Ref: 719
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 10.E.4. Analyze peptic ulcer disease (PUD) as it relates to inflammation. Apply the nursing process in providing culturally competent care to an individual with PUD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with peptic ulcer disease.

7) A client with *Helicobacter pylori* asks the nurse why bismuth (Pepto-Bismol) has been prescribed along with oral antibiotics for treatment. Which information should the nurse include when explaining about the use of Pepto-Bismol for treatment of this health problem? **Select all that apply.**
A) "It helps prevent the side effects of antibiotics."
B) "It increases stomach acid to help kill bacteria."
C) "It helps relieve ulcer-related constipation."
D) "It is effective with inhibiting bacterial growth."
E) "It stimulates the production of substances that promote ulcer healing."
Answer: D, E
Explanation: A) Bismuth does not prevent all side effects of antibiotics.
B) Bismuth does not increase stomach acid.
C) Bismuth is used to relieve diarrhea, not constipation.
D) Bismuth compounds (Pepto-Bismol) are added to the antibiotic regimen to inhibit bacterial growth.
E) Bismuth compounds stimulate mucosal bicarbonate and prostaglandin production to promote ulcer healing.
Page Ref: 760
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 10.E.3. Analyze peptic ulcer disease (PUD) as it relates to inflammation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with PUD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with peptic ulcer disease.

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8) The nurse is planning a teaching session regarding peptic ulcers for the residents of an assisted-living complex. Which concepts about peptic ulcer disease should the nurse include in the presentation to the residents? **Select all that apply.**
A) A colonoscopy is the most common test used to diagnose the presence of a gastric ulcer.
B) Gastric ulcers are more common than duodenal ulcers.
C) Many peptic ulcers are infected with *Helicobacter pylori* (*H. pylori*) and are treated with antibiotics.
D) The first sign of a peptic ulcer may be serious gastrointestinal bleeding.
E) An individual with a peptic ulcer will most likely experience pain when the stomach is empty.
Answer: C, D, E
Explanation: A) Tests used to diagnose a gastric ulcer include endoscopy and *H. pylori* testing.
B) Duodenal ulcers are more common than gastric ulcers.
C) Peptic ulcers that are infected with *H. pylori* will often be treated with antibiotics.
D) The client with a peptic ulcer may be largely asymptomatic until there is an episode of gastrointestinal bleeding.
E) The individual who has a peptic ulcer will most likely have abdominal pain when the stomach is empty.
Page Ref: 757
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 10.E.3. Analyze peptic ulcer disease (PUD) as it relates to inflammation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with PUD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with peptic ulcer disease.

9) The nurse is educating a client with peptic ulcer disease (PUD) about *Helicobacter pylori* (*H. pylori*) and its role in PUD. Which statements by the nurse are appropriate to include in the teaching session? **Select all that apply.**

A) "*H. pylori* produces enzymes that improve the efficacy of mucous gel in protecting the gastric mucosa."

B) "*H. pylori* infection is found in about 25% of individuals with PUD."

C) "Your inflammatory response to *H. pylori* contributes to gastric cell damage."

D) "*H. pylori* infection increases production of gastric acids."

E) "*H. pylori* infection is spread by droplets in the air."

Answer: C, D

Explanation: A) The bacteria produce enzymes that reduce the efficacy of mucous gel in protecting the gastric mucosa.

B) *H. pylori* infection, found in about 70% of individuals who have PUD, is unique in colonizing the stomach.

C) The host's inflammatory response to *H. pylori* contributes to gastric epithelial cell damage without producing immunity to the infection.

D) *H. pylori* infection also increases the production of gastric acids.

E) It is spread from individual to individual (oral-oral or fecal-oral).

Page Ref: 757

Cognitive Level: Understanding

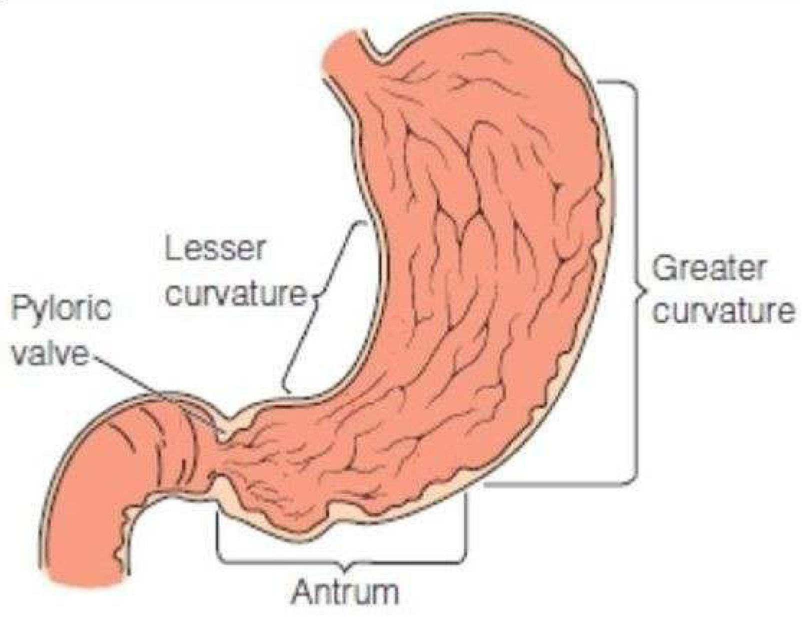
Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 10.E.1. Analyze peptic ulcer disease (PUD) as it relates to inflammation. Describe the pathophysiology of PUD.

MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with peptic ulcer disease.

10)



Which two areas are the most likely locations for a gastric ulcer to develop? **Select all that apply.**

A) Lesser curvature
B) Greater curvature
C) Distal to the pylorus
D) Proximal to the pylorus
E) Pyloric valve

Answer: A, D

Explanation: A) Gastric ulcers often are found on the lesser curvature, and the area immediately proximal (not distal) to the pylorus.
B) Gastric ulcers are not often found on the greater curvature.
C) Gastric ulcers are not found distal to the pylorus.
D) Gastric ulcers often are found on the area immediately proximal to the pylorus.
E) Gastric ulcers do not develop at the area of the pyloric valve.

Page Ref: 757
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 10.E.1. Analyze peptic ulcer disease (PUD) as it relates to inflammation. Describe the pathophysiology of PUD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with peptic ulcer disease.

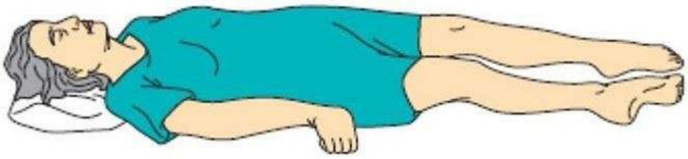
11) Why is steatorrhea a common manifestation of Zollinger-Ellison syndrome?
A) The high levels of hydrochloric acid associated with Zollinger-Ellison syndrome lead to impaired protein digestion.
B) The high levels of hydrochloric acid associated with Zollinger-Ellison syndrome lead to impaired fat digestion.
C) The large colonies of *Helicobacter pylori* (*H. pylori*) associated with Zollinger-Ellison syndrome lead to impaired protein digestion.
D) The large colonies of *H. pylori* associated with Zollinger-Ellison syndrome lead to impaired fat digestion.
Answer: B
Explanation: A) The high levels of hydrochloric acid associated with Zollinger-Ellison syndrome do not lead to impaired protein digestion.
B) Zollinger-Ellison syndrome is a form of PUD caused by a gastrinoma, or gastrin-secreting tumor. Gastrin is a hormone that stimulates the secretion of pepsin and hydrochloric acid. The high levels of hydrochloric acid entering the duodenum overwhelm the protective buffering mechanism; the result is diarrhea and steatorrhea from impaired fat digestion and absorption.
C) *Helicobacter pylori* (*H. pylori*) does not cause Zollinger-Ellison syndrome.
D) *Helicobacter pylori* (*H. pylori*) does not cause Zollinger-Ellison syndrome.
Page Ref: 758
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 10.E.1. Analyze peptic ulcer disease (PUD) as it relates to inflammation. Describe the pathophysiology of PUD.
MNL LO: Demonstrate understanding of the concept of inflammation in the care of a patient with peptic ulcer disease.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e **(Pearson)**
Module 11 Intracranial Regulation

The Concept of Intracranial Regulation

1) A client who sustained a head injury from a motor vehicle crash begins to demonstrate an abnormal posture. (See image.) Which should the nurse suspect is occurring with the client's brain functioning?



A) Improved level of consciousness
B) Developing a seizure disorder
C) Brainstem impairment
D) Corticospinal tract impairment
Answer: C
Explanation: A) Altered level of consciousness (LOC), not improved level of consciousness, is an early manifestation of the deterioration of the function of the cerebral hemispheres.
B) Seizure disorders have various types of motor postures.
C) Structures in the brainstem have characteristic changes in motor function. Evidence of brainstem involvement includes decerebrate posturing that is distinguished by rigid extension.
D) Corticospinal tract impairment is characterized by decorticate posturing, which is rigid flexion.
Page Ref: 773
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.2. Differentiate alterations to intracranial regulation.
MNL LO: Analyze the concept of intracranial regulation and its application to nursing care.

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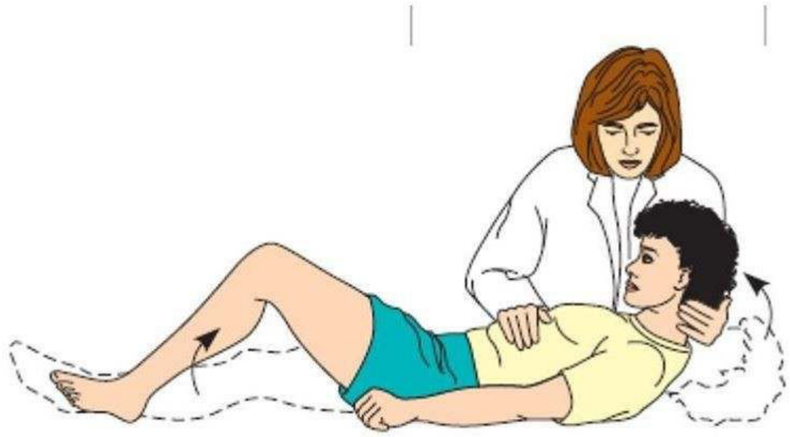
2) An adult client with increased intracranial pressure caused from a head injury has a Glasgow Coma Scale (GCS) score of 6. Which finding will the nurse expect to assess in this client?
A) Extension to painful stimuli
B) Spontaneous eye opening
C) Oriented to time, place, and person
D) Withdraws to touch
Answer: A
Explanation: A) The client's score is low, so the finding of extension to painful stimuli, a 2 out of a possible 6 for motor response, is most likely for this client.
B) Findings of spontaneous eye opening (a 4 on the scale for eye opening, the maximum score) is unlikely.
C) Being oriented to time, place, and person (a 5 for verbal response and also the maximum score for that component) is unlikely.
D) An assessment finding of withdraws to touch would be more typical of an infant or young child, not an adult, and would be a 5 out of 6 for motor response.
Page Ref: 779
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.2. Differentiate alterations to intracranial regulation.
MNL LO: Analyze the concept of intracranial regulation and its application to nursing care.

3) A school-age client is experiencing photophobia, a sore neck, chills, and fever. For which reason did the nurse use the technique in the exhibit when assessing the client?



A) It is a routine part of the physical assessment.
B) Flexion of the hips or knees would be consistent with meningitis.
C) The nurse was assessing range of motion of the neck.
D) This technique assesses optic nerve functioning.
Answer: B
Explanation: A) Assessing for the Brudzinski sign is not a routine part of the physical assessment.
B) The client's manifestations of a sore neck, chills, fever, and photophobia are consistent with meningitis. Assessing for the Brudzinski sign can rule in meningitis because flexing the client's head to the chest will trigger flexion of the hips and knees in clients with meningeal irritation.
C) This maneuver is not done to assess for neck range of motion.
D) This maneuver is not done to assess for optic nerve functioning.
Page Ref: 787
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.5. Differentiate common assessment procedures and tests used to examine intracranial regulation.
MNL LO: Analyze the concept of intracranial regulation and its application to nursing care.

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4) The nurse is reviewing results of diagnostic testing performed on a client with increased intracranial pressure (ICP). Which diagnostic test results should the nurse make available to the healthcare provider for review? **Select all that apply.**
A) Bronchoscopy results
B) MRI result
C) Head CT scan with and without contrast
D) Electroencephalogram
E) Cerebrospinal fluid differential cell count
Answer: B, C, D, E
Explanation: A) Bronchoscopy is not performed routinely for a client with increased intracranial pressure.
B) Diagnosis of increased ICP is made on the basis of observation and neurologic assessment; even subtle changes can be clinically significant. Testing can include an MRI.
C) Diagnosis of increased ICP is made on the basis of observation and neurologic assessment; even subtle changes can be clinically significant. Testing can include CT scan with and without contrast.
D) Diagnosis of increased ICP is made on the basis of observation and neurologic assessment; even subtle changes can be clinically significant. Testing can include an electroencephalogram.
E) Diagnosis of increased ICP is made on the basis of observation and neurologic assessment; even subtle changes can be clinically significant. Testing can include cerebrospinal fluid evaluation.
Page Ref: 787
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 11.5. Differentiate common assessment procedures and tests used to examine intracranial regulation.
MNL LO: Analyze the concept of intracranial regulation and its application to nursing care.

5) The nurse is determining ways to decrease environmental stimuli for a client with increased intracranial pressure. Which actions should the nurse take to support this client's care need? **Select all that apply.**
A) Limit the client's visitors.
B) Teach family to speak softly and minimize touching.
C) Elevate the head of the bed.
D) Raise pads and bedrails.
E) Keep the room dark and quiet.
Answer: A, B, E
Explanation: A) Visitors should be limited.
B) Family members should be encouraged to talk to the client in a soft voice with minimal touching.
C) Elevating the head of the bed is important to reducing intracranial pressure but has no effect on stimulation.
D) Raising pads and bedrails is important because of the possibility of seizures but does not relate to stimulation.
E) A dark, quiet room is important to reduce stimuli.
Page Ref: 776
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 11.6. Analyze independent interventions nurses can implement for patients with alterations in intracranial regulation.
MNL LO: Analyze the concept of intracranial regulation and its application to nursing care.

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6) The nurse is planning care for an older adult client with a head injury secondary to a motor vehicle crash. Which information should the nurse keep in mind when planning this client's care? **Select all that apply.**
A) Anxiety, illness, and pain can alter the ability to learn.
B) Baseline reflexes may be slower or diminished.
C) Impulse transmission and reactions to stimuli are slower.
D) Neurologic assessment should be completed in a single session.
E) Impairment in vision and hearing should be taken into consideration.
Answer: A, B, C, E
Explanation: A) In the older client, anxiety, illness, and pain can alter the ability to learn.
B) Reflexes may be slower or diminished in an older client.
C) Responses to stimuli are slower because of reduced impulse transmission.
D) For an older client, full neurologic assessment can be lengthy. Conduct the assessment in several sessions, if indicated, and cease the tests if the client is noticeably fatigued.
E) Many older adults have some impairment of hearing and vision, which should be taken into consideration when planning care.
Page Ref: 791
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 11.8. Differentiate considerations related to the assessment and care of patients with alterations in intracranial regulation throughout the lifespan.
MNL LO: Analyze the concept of intracranial regulation and its application to nursing care.

7) A client with a head injury is demonstrating signs of increased intracranial pressure (IICP). Which classifications of medications should the nurse anticipate administering to this client? **Select all that apply.**

A) Osmotic diuretics
B) Antibiotics
C) Antiseizure drugs
D) Histamine H_2 antagonists
E) Antipyretics

Answer: A, C, D, E

Explanation: A) Osmotic diuretics are commonly used to reduce ICP.
B) Antibiotics are not routinely prescribed as treatment for IICP.
C) Antiseizure drugs are often required to manage seizure activity associated with brain injury and IICP.
D) Gastrointestinal prophylaxis with intravenous histamine H_2 antagonists is often used because clients with IICP are at increased risk for developing stress gastritis and ulcers.
E) Antipyretics such as acetaminophen are used alone or in combination with a hypothermia blanket to treat hyperthermia.

Page Ref: 789
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 11.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in intracranial regulation.
MNL LO: Analyze the concept of intracranial regulation and its application to nursing care.

8) The nurse is performing a neurologic assessment on a 9-year-old child who has displayed unexplained changes in behavior. Which assessment finding is consistent with a neurologic deficit?

A) Child has a negative Babinski reflex.
B) Child recalls names of well-known cartoon characters.
C) Child is able to walk backward heel to toe.
D) Child is incapable of balancing on one foot.

Answer: D

Explanation: A) A positive Babinski reflex is abnormal after the child ambulates or reaches 2 years of age.
B) Ability to recall names of well-known cartoon characters would show a normal level of recall.
C) Children should be able to heel-toe walk backward by 6 years of age.
D) Children should be able to balance on one foot for 5 seconds by 4 years of age.

Page Ref: 790
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 11.8. Differentiate considerations related to the assessment and care of patients with alterations in intracranial regulation throughout the lifespan.
MNL LO: Analyze the concept of intracranial regulation and its application to nursing care.

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9) The nurse is reviewing the anatomy of the nervous system. Which part of the body should the nurse identify as that which controls reflexes and regulates activities such as vomiting, hiccupping, coughing, and sneezing?

A) Brainstem
B) Hypothalamus
C) Spinal cord
D) Thalamus

Answer: A

Explanation: A) The brainstem is made up of the midbrain, pons, and medulla oblongata. The brainstem controls reflexes and influences all basic life functions including breathing, blood pressure, and heart rate. The brainstem also regulates activities such as vomiting, hiccupping, coughing, and sneezing.

B) The hypothalamus is the autonomic control center, and it is involved in regulating activities such as heart rate, blood pressure, respiratory rate and depth, pain, pleasure, and fear.

C) The spinal cord transmits impulses to and from the brain.

D) The thalamus is the brain's relay center; it takes all incoming nerve impulses and sends those signals to the correct region of the brain.

Page Ref: 769
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 11.1. Analyze the physiology of intracranial regulation.
MNL LO: Analyze the concept of intracranial regulation and its application to nursing care.

10) The nurse is caring for a client recovering from a stroke. Which lobe of the brain should the nurse recall as that which stores memory and interprets auditory stimuli?
A) Frontal
B) Occipital
C) Parietal
D) Temporal
Answer: D
Explanation: A) The frontal lobe is involved with speech, thought, learning, emotion, and voluntary movement.
B) The occipital lobe processes vision.
C) The parietal lobe processes sensory information, including shapes, temperature, pain, and two-point discrimination.
D) The temporal lobe of the brain stores memory and interprets auditory stimuli.
Page Ref: 769
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.1. Analyze the physiology of intracranial regulation.
MNL LO: Analyze the concept of intracranial regulation and its application to nursing care.

11) The nurse is reviewing the relationship between the neurologic and respiratory systems. Which alteration should the nurse expect to occur if a client with a decrease in level of consciousness has a decrease in respirations?
A) Acid-base balance
B) Cognition
C) Mobility
D) Oxygenation
Answer: D
Explanation: A) An increase in CO_2 leading to vasodilation and increased intracranial pressure is involved in the relationship between intracranial regulation and acid-base balance.
B) Alterations in intracranial regulation can lead to impaired cognitive function, ranging from mild confusion to lack of consciousness.
C) Clients with alterations in intracranial regulation will have different mobility needs based on the underlying pathology.
D) A decrease in level of consciousness may lead to a decrease in respiration describes the relationship between intracranial regulation and oxygenation.
Page Ref: 779
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.3. Outline the relationship between intracranial regulation and other concepts.
MNL LO: Analyze the concept of intracranial regulation and its application to nursing care.

12) The nurse is reviewing the use of protective equipment for outdoor activities and vehicle restraint systems with a group of community members. Which alteration in intracranial regulation will these health promotion activities prevent?

A) Prescription drug side effects
B) Congenital hydrocephalus
C) Stroke
D) Trauma

Answer: D

Explanation: A) Prescription drug side effects is a medical condition that can't be prevented with protective equipment or vehicle restraint systems.

B) Congenital hydrocephalus can cause increased intracranial pressure in infants but is genetic and can't be affected by anticipatory guidance.

C) Stroke is a medical condition that can't be prevented with protective equipment or vehicle restraint systems.

D) Health promotion efforts concerning intracranial regulation that focus on the proper use of protective equipment for outdoor activities and vehicle restraint systems are designed to anticipate and prevent trauma as a cause for alterations to intracranial regulation.

Page Ref: 778
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 11.4. Explain the promotion of healthy intracranial regulation.
MNL LO: Analyze the concept of intracranial regulation and its application to nursing care.

Exemplar 11.A Increased Intracranial Pressure

1) A school-age client with a head injury has a heart rate of 48 bmp, blood pressure 132/58 mmHg, and respiratory rate 28 and irregular. Which conclusion should the nurse make?
A) These vital signs indicate respiratory distress.
B) These vital signs indicate increased intracranial pressure.
C) These vital signs indicate cardiovascular disease.
D) These vital signs indicate that this child has a spinal cord injury.
Answer: B
Explanation: A) Respiratory distress is often indicated by a respiratory rate that is lower than normal.
B) These vital signs show a wide pulse pressure (increased systolic blood pressure and lowered diastolic blood pressure), slow heart rate, and respirations that are irregular, all indicating possible significant increased intracranial pressure. Normal heart rate for an awake child at this age is 70-110. Normal blood pressure is 92-126/55-86. Normal respirations are 20 and regular. These vital signs are a sign of increased intracranial pressure.
C) Cardiovascular disease is a chronic condition, not an acute condition that results from trauma.
D) If it was a spinal cord injury, and neurogenic shock weas suspected, the child would be hypotensive.
Page Ref: 793
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.A. Analyze increased intracranial pressure (ICP) as it relates to intracranial regulation. Identify the clinical manifestations of increased ICP.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with increased intracranial pressure.

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2) The nurse is caring for a client being monitored for increased intracranial pressure (IICP). Using the Monro-Kellie hypothesis as a basis for explanation, which comment by the nurse to the client's family would be most appropriate?
A) "It is normal for brain pressure to increase in times of stress."
B) "Increasing brain pressure decreases the amount of blood flow to the brain itself."
C) "The pressure in the brain is increasing because the brain is shrinking."
D) "Because there is more pressure in the brain, the blood flow is also increasing."
Answer: B
Explanation: A) It is not normal for brain pressure to increase in times of stress.
B) The Monro-Kellie hypothesis states that a dynamic equilibrium exists among the three components (brain, cerebrospinal fluid, and blood) of the skull. A change in the volume of any component risks a decrease in the remaining components to maintain normal intracranial pressures.
C) The pressure in the brain does not increase because the brain in shrinking.
D) Increased pressure in the brain does not increase blood flow to the brain.
Page Ref: 793
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 11.A. Analyze increased intracranial pressure (ICP) as it relates to intracranial regulation. Describe the pathophysiology of increased ICP.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with increased intracranial pressure.

3) A school-age client is being discharged after receiving a ventriculoperitoneal (VP) shunt as treatment for increased intracranial pressure (ICP). Which statement should indicate to the nurse that teaching provided to the parents about shunt malfunction has been effective?
A) "If our child has a bulging soft spot, we will call the doctor."
B) "If our child develops an altered level of consciousness, we will notify the doctor."
C) "If we notice our child's head is expanding, we will notify the doctor."
D) "If our child vomits, we will call the doctor."
Answer: B
Explanation: A) Because the bones in the skull have not yet fused, an infant with increased ICP may have bulging fontanels, separated sutures on the skull, drowsiness, or vomiting. In most children by age 8, the cranial suture lines have fused and the fontanels are closed, so a bulging soft spot would not be a common symptom of shunt malfunction and an increase in intracranial pressure.
B) An altered level of consciousness would be a symptom of shunt malfunction and increasing intracranial pressure.
C) In most children by age 8, the cranial suture lines have fused and the fontanels are closed, so an expanding head size would not be a common symptom of shunt malfunction and an increase in intracranial pressure.
D) In children, and as ICP increases in infants, the signs and symptoms of increased ICP present similarly to adults. Examination may reveal headaches, weakness, eye movement disturbances, behavioral changes, decreased level of consciousness (LOC), or seizures.
Page Ref: 799
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 11.A. Analyze increased intracranial pressure (ICP) as it relates to intracranial regulation. Differentiate care of patients with increased ICP across the lifespan.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with increased intracranial pressure.

4) The nurse identifies the problem of a risk for infection for a child who sustained a brain injury during an automobile accident. Which intervention would be appropriate to include in this client's plan of care related to this problem?

A) Teach the family the importance of using seat belts.

B) Change the client's dressings on a prescribed basis.

C) Refer the family to support services in the community.

D) Explain rules for visiting in the Intensive Care Unit.

Answer: B

Explanation: A) While families may need education about seat belts, it is not the optimal time to implement such teaching at this point in the crisis.

B) A nursing intervention that would support the problem risk for infection would be changing the client's dressings on a prescribed basis because wet dressings can be a source of infection.

C) While families may need education about sources of support, it is not the optimal time to implement such teaching at this point in the crisis.

D) Timelines for visitation are appropriate but are not the priority.

Page Ref: 797

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 11.A. Analyze increased intracranial pressure (ICP) as it relates to intracranial regulation. Apply the nursing process in providing culturally competent care to an individual with increased ICP.

MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with increased intracranial pressure.

5) While caring for a client with increased intracranial pressure (ICP), a family member asks to assist. Which interventions are appropriate for the nurse to teach the family member regarding this client's care? **Select all that apply.**
A) Maintain head of the bed elevated to 30 degrees.
B) Position client in a supine position.
C) Decrease stimuli.
D) Keep bedrails raised.
E) Keep the client in a stationary position.
Answer: A, C, D
Explanation: A) For clients with increased ICP, the head of the bed should be elevated. The degree depends on the reaction of the client to the position; 30 degrees is usually appropriate, but this can vary by the client.
B) The head of the bed should be elevated. The degree depends on the reaction of the client to the position.
C) Decrease stimuli for a client with increased ICP.
D) For clients with increased ICP, the bedrails should be raised.
E) Clients with increased ICP must not remain stationary, but position changes should be done less frequently than for other clients because turning, skin care, and passive range of motion exercises can elicit posturing, which also causes increased ICP.
Page Ref: 798
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: IX.3. 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 11.A. Analyze increased intracranial pressure (ICP) as it relates to intracranial regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with increased ICP.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with increased intracranial pressure.

6) The nurse is providing care for a client with a head injury and wants to decrease the client's risk for developing increased intracranial pressure (IICP). Which assessment data indicates that the nurse is successful?

A) Body temperature elevated 1 degree in 4 hours
B) Absent gag reflex
C) Pupils equal and reactive to light
D) Sluggish response to verbal stimuli

Answer: C

Explanation: A) An elevated temperature with increased oxygen consumption further increases ICP.

B) Pressure on the brainstem may compromise the function of protective mechanisms such as the gag reflex.

C) Pupillary responses mirror the status of the midbrain and pons.

D) A sluggish response to verbal stimuli could indicate increasing ICP.

Page Ref: 793

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 11.A. Analyze increased intracranial pressure (ICP) as it relates to intracranial regulation. Apply the nursing process in providing culturally competent care to an individual with increased ICP.

MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with increased intracranial pressure.

7) The nurse is caring for a pregnant client with a history of idiopathic intracranial hypertension (IIH) and optic neuritis. Which outcome should the nurse least assume regarding this client?
A) The client will deliver her baby via cesarean birth.
B) Pregnancy-related weight gain should be kept to no more than 9 kg.
C) The client has been prescribed a medication to treat the IIH.
D) The second stage of labor should not be prolonged.
Answer: A
Explanation: A) Pregnant clients with IIH usually have a normal vaginal delivery.
B) For these women, it is recommended that pregnancy-related weight gain be on the lower end (5-9 kg).
C) Medications to treat IIH can usually be taken throughout pregnancy.
D) If there is optic nerve dysfunction, the second stage of labor should not be prolonged, but otherwise no special care must be provided to the pregnant client with IIH.
Page Ref: 756
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 11.A. Analyze increased intracranial pressure (ICP) as it relates to intracranial regulation. Differentiate care of patients with increased ICP across the lifespan.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with increased intracranial pressure.

8) The nurse is planning care for a client who is experiencing increased intracranial pressure (ICP) secondary to a head injury sustained during a motor vehicle crash. Which intervention is a priority for this client?
A) Ensuring adequate oxygenation
B) Maintaining a calm environment
C) Monitoring for nausea and vomiting
D) Controlling pain
Answer: A
Explanation: A) Ensuring adequate oxygenation to support brain function is the most important step in management of increased ICP.
B) A calm environment is secondary to maintaining adequate oxygenation.
C) Monitoring for nausea and vomiting (a sign of increased ICP) would be secondary to maintaining adequate oxygenation.
D) Pain control would be secondary to maintaining adequate oxygenation.
Page Ref: 798
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 11.A. Analyze increased intracranial pressure (ICP) as it relates to intracranial regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with increased ICP.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with increased intracranial pressure.

9) The nurse is reviewing the physiology of the central nervous system. Which substance will the nurse identify that is imbalanced and causes hydrocephalus?

A) Blood
B) Cerebrospinal fluid
C) Oxygen
D) Water

Answer: B

Explanation: A) Hydrocephalus is not caused by an imbalance between production and absorption of blood.

B) Hydrocephalus results from an imbalance between production and absorption of cerebrospinal fluid (CSF) which causes too much CSF to accumulate in the brain and the ventricles to widen.

C) Hydrocephalus is not caused by an imbalance between production and absorption of oxygen.

D) Hydrocephalus is not caused by an imbalance between production and absorption of water.

Page Ref: 792

Cognitive Level: Remembering

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 11.A. Analyze increased intracranial pressure (ICP) as it relates to intracranial regulation. Describe the etiology of increased ICP.

MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with increased intracranial pressure.

10) The nurse is teaching a group of adolescents on general safety. Which adverse outcome can be prevented if the nurse recommends the use of seat belts and to avoid mobile device use while driving?
A) Cerebral edema
B) Head trauma
C) Hydrocephalus
D) Intracranial tumors
Answer: B
Explanation: A) Guidance related to wearing seat belts and avoiding mobile device use while driving will not prevent the development of cerebral edema.
B) Guidance related to wearing seat belts and avoiding mobile device use while driving is intended to lower the risk of head trauma.
C) Guidance related to wearing seat belts and avoiding mobile device use while driving will not prevent the development of hydrocephalus.
D) Guidance related to wearing seat belts and avoiding mobile device use while driving will not prevent the development of intracranial tumors.
Page Ref: 793
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 11.A. Analyze increased intracranial pressure (ICP) as it relates to intracranial regulation. Compare the risk factors and prevention of increased ICP.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with increased intracranial pressure.

11) The nurse is reviewing autoregulation in the brain. Which events are associated with the loss of autoregulation?
A) Both intracranial pressure and cerebral perfusion decrease.
B) Both intracranial pressure and cerebral perfusion increase.
C) Intracranial pressure decreases and cerebral perfusion increases.
D) Intracranial pressure increases and cerebral perfusion decreases.
Answer: D
Explanation: A) Intracranial pressure and cerebral perfusion do not decrease in autoregulation.
B) Intracranial pressure and cerebral perfusion do not increase in autoregulation.
C) Intracranial pressure does not decrease and cerebral perfusion does not increase in autoregulation.
D) With loss of autoregulation, ICP continues to increase and cerebral perfusion decreases. Cerebral tissue becomes ischemic, and manifestations of cellular hypoxia appear.
Page Ref: 792
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.A. Analyze increased intracranial pressure (ICP) as it relates to intracranial regulation. Identify the clinical manifestations of increased ICP.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with increased intracranial pressure.

12) The nurse is caring for a client who is demonstrating signs of increased intracranial pressure (ICP). Which information about the Monro-Kellie hypothesis should the nurse recall when planning this client's care?
A) An imbalance in the volumes of the brain, blood, and cerebrospinal fluid (CSF) will trigger a compensatory response.
B) Normal intracranial pressure requires that the volumes of the brain, blood, and CSF are low.
C) The brain can compress dynamically to compensate for an increase in blood or CSF volume.
D) The volume of the blood must remain constant regardless of the volume of the brain and CSF.
Answer: A
Explanation: A) In adults, the rigid cranial cavity created by the skull is normally filled to capacity with three essentially noncompressible elements: the brain, cerebrospinal fluid, and blood. A state of dynamic equilibrium exists: If the volume of any of the three components increases, the volume of the others must decrease to maintain normal pressures in the cranial cavity. This relationship is known as the Monro-Kellie hypothesis.
B) Normally either the blood or CSF would shift out of the cranium to compensate for increased volume of one of these three components.
C) The brain is noncompressible.
D) The volume of these components must remain in balance, not be low.
Page Ref: 792
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.A. Analyze increased intracranial pressure (ICP) as it relates to intracranial regulation. Describe the pathophysiology of increased ICP.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with increased intracranial pressure.

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Exemplar 11.B Seizure Disorders

1) The nurse observes a school-age client have an absence seizure. Which statement will the nurse likely include when documenting this seizure?

A) "Reported experiencing tingling sensations but denied loss of consciousness."

B) "Became unconscious, and all four extremities were jerking uncontrollably for 2 minutes."

C) "Repeatedly moved from the chair to the bed while touching the arms for a length of 2 minutes."

D) "Sat very still and was unresponsive with a blank stare for 30 seconds."

Answer: D

Explanation: A) During a simple partial seizure, if the sensory portion of the cortex is involved, manifestations may include abnormal sensations such as tingling, numbness, or hallucinations, but there is no alteration in consciousness.

B) Loss of consciousness and jerking of extremities is characteristic of tonic-clonic seizures.

C) Aimless activity may happen during complex partial seizures.

D) Absence (petit mal) seizures are characterized by sudden, brief cessation of all motor activity accompanied by a blank stare and unresponsiveness. These seizures are more common in children than in adults.

Page Ref: 801

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Documentation

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Learning Outcome: 11.B. Analyze seizure disorders as they relate to intracranial regulation. Identify the clinical manifestations of seizure disorders.

MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with seizure disorder.

2) A preschool-age client with myoclonic seizures has been following a ketogenic diet for the last 6 months to reduce seizure activity and is complaining of left-sided lower abdominal pain. Which complication of the ketogenic diet should the nurse suspect the client is experiencing?
A) Bowel obstruction
B) Kidney stone
C) Urinary tract infection
D) Appendicitis
Answer: B
Explanation: A) A ketogenic diet does not typically cause bowel obstructions, but it can cause constipation.
B) Renal calculi, or kidney stones, are seen in 5% of children on a ketogenic diet.
C) Urinary tract infections are not a result of a ketogenic diet.
D) Appendicitis does not occur as a result of the ketogenic diet.
Page Ref: 807
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.B. Analyze seizure disorders as they relate to intracranial regulation. Differentiate care of patients with seizure disorders across the lifespan.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with seizure disorder.

3) The nurse provides teaching about phenytoin (Dilantin) to the mother of a school-age client with a seizure disorder. Which statement made by the mother indicates that teaching has been effective?
A) "I will give the medicine on an empty stomach so it will absorb better."
B) "I will check the gums and increase visits to the dentist."
C) "I will use a carbonated beverage to dilute the medication."
D) "I will allow the tablet to be chewed."
Answer: B
Explanation: A) There is no dietary recommendation for taking phenytoin (Dilantin).
B) Client teaching for school-age and adolescent clients taking phenytoin (Dilantin) is to discuss the importance of regular dental care because of phenytoin's effects on the gingiva. Gingival hyperplasia can occur in clients who take phenytoin (Dilantin).
C) Carbonated beverages should not be used to dilute medication doses.
D) Unless the medication is prescribed as chewable, the client should not be permitted to chew the dose.
Page Ref: 808
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 11.B. Analyze seizure disorders as they relate to intracranial regulation. Differentiate care of patients with seizure disorders across the lifespan.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with seizure disorder.

4) The nurse identifies the problem of risk for trauma as appropriate for a client with a seizure disorder. Which actions will the nurse take when this client experiences a seizure? **Select all that apply.**
A) Turn the client to a lateral position, if possible.
B) Stay with the client.
C) Insert a tongue blade into the client's mouth.
D) Call for help.
E) Restrain the client.
Answer: A, B, D
Explanation: A) If possible, the client should be turned onto the lateral position, not supine, to allow for any secretions to drain out of the mouth.
B) The nurse should stay with the client.
C) Research has found that more injury can occur to the client if the caregiver tries to place something in the mouth during the seizure than if the caregiver does not.
D) The nurse should call for assistance, if needed.
E) A client should never be restrained during a seizure.
Page Ref: 809
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 11.B. Analyze seizure disorders as they relate to intracranial regulation. Apply the nursing process in providing culturally competent care to individuals with seizure disorders.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with seizure disorder.

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5) The nurse is planning discharge teaching for a child with epilepsy who is prescribed phenytoin (Dilantin). Which nutrient should the nurse recommend the client increase in the diet?
A) Carbohydrates
B) Fats
C) Protein
D) Calcium
Answer: D
Explanation: A) Clients on prolonged antiseizure drug therapy do not need to increase the intake of carbohydrates.
B) Clients on prolonged antiseizure drug therapy do not need to increase the intake of fats.
C) Clients on prolonged antiseizure drug therapy do not need to increase the intake of protein.
D) Phenytoin can contribute to demineralization of bone. The serum calcium level should be monitored and calcium supplements may be required.
Page Ref: 806
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 11.B. Analyze seizure disorders as they relate to intracranial regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a seizure disorder.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with seizure disorder.

6) The nurse visits the home of an adolescent being treated for a tonic-clonic seizure disorder. Which observations indicate that outcomes for care have been achieved? **Select all that apply.**

A) The client is not driving.
B) The client has not had a seizure for 1 month.
C) The client is participating on the school basketball team.
D) The client has bruises on both arms.
E) The client is complaining of constipation.

Answer: A, B, C

Explanation: A) For a client with a tonic-clonic seizure disorder, driving privileges will be suspended until seizure activity is controlled and client is seizure-free for a period of time determined by state statutes, so this client would likely not be able to drive legally until the seizures are controlled for some time.
B) Cessation of seizure activity indicates that medication therapy has been effective.
C) The client's participation in well-supervised sports and activities will likely enhance the client's self-esteem, and it indicates that care has been effective.
D) Physical bruising may indicate that treatment for a seizure disorder has not been effective.
E) Constipation is a complication of a ketogenic diet used to help control seizure activity and would indicate that care has not been effective.

Page Ref: 808
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 11.B. Analyze seizure disorders as they relate to intracranial regulation. Apply the nursing process in providing culturally competent care to individuals with seizure disorders.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with seizure disorder.

7) An older adult client is experiencing a tonic-clonic (grand mal) seizure exceeding 10 minutes in length. Which medication should the nurse prepare to administer to this client?
A) Intramuscular injection of diazepam
B) Intramuscular injection of phenytoin
C) Intravenous diazepam slowly over several minutes
D) Oral administration of gabapentin
Answer: C
Explanation: A) Diazepam may be administered by an IV slowly over several minutes, but not intramuscularly.
B) Phenytoin is administered intravenously for longer term control of seizures.
C) Grand mal, or tonic-clonic, seizure requires prompt management if it continues after 10 minutes has elapsed. Diazepam may be administered by an IV slowly over several minutes.
D) Gabapentin is an antiseizure drug used to prophylactically reduce or control seizure activity; gabapentin is administered orally 2 hours after antacids, which would be inappropriate for this client.
Page Ref: 804
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 11.B. Analyze seizure disorders as they relate to intracranial regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a seizure disorder.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with seizure disorder.

8) A toddler-age client having a tonic-clonic (grand mal) seizure has the jaws clamped shut. Which action should the nurse take?
A) Place a tongue blade between the child's jaws.
B) Restrain the child to prevent injury.
C) Prepare the suction equipment.
D) Stay with the child to observe for complications.
Answer: D
Explanation: A) Be sure nothing is placed in the child's mouth during a seizure.
B) The child should not be restrained during a seizure.
C) Suction equipment should already be set up at the bedside before a seizure begins.
D) During a seizure, the nurse remains with the child, watching for complications.
Page Ref: 809
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 11.B. Analyze seizure disorders as they relate to intracranial regulation. Apply the nursing process in providing culturally competent care to individuals with seizure disorders.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with seizure disorder.

9) The nurse is reviewing the different types of seizures. Which type of seizure should the nurse identify as one that does not affect memory or awareness and occurs when abnormal electrical activity is contained to a limited area of the brain?
A) Absence
B) Atonic
C) Generalized
D) Focal
Answer: D
Explanation: A) An absence seizure is a generalized seizure that involves a brief cessation of all motor activity accompanied by blank stare and unresponsiveness.
B) Atonic seizures cause loss of muscle control, which often leads to the individual falling and therefore secondary injuries may occur.
C) A generalized seizure is caused by abnormal electrical discharges that originate from both hemispheres of the brain.
D) Focal seizures (also known as partial seizures) occur when abnormal electrical activity is contained to a limited area of the brain.
Page Ref: 800
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.B. Analyze seizure disorders as they relate to intracranial regulation. Describe the pathophysiology of seizure disorders.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with seizure disorder.

10) A client is diagnosed with a seizure disorder that is not provoked by known stimuli. In which way should the nurse categorize this seizure disorder?
A) Acquired
B) Congenital
C) Febrile
D) Idiopathic
Answer: D
Explanation: A) An acquired seizure may be caused by underlying pathologic conditions such as trauma, infection, hypoglycemia, hypotonic dehydration, electrolyte imbalance, endocrine dysfunction, toxins, tumors, or lesions that may be manifested at any time.
B) Congenital is not a type of seizure.
C) Febrile seizures usually occur in children as the result of a rapid temperature rise above 102.2°F (39°C, rectal), often in association with an acute illness.
D) An idiopathic seizure is not provoked by known stimuli.
Page Ref: 801
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.B. Analyze seizure disorders as they relate to intracranial regulation. Describe the etiology of seizure disorders.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with seizure disorder.

11) A client with a seizure disorder asks what a seizure threshold is. Which response should the nurse make?
A) The threshold is the length of time a seizure will last.
B) The threshold is the limit beyond which the occurrence of a seizure is possible.
C) Unless a seizure results in convulsions, it is considered to be below the threshold.
D) When the threshold is exceeded, a seizure is considered to be generalized.
Answer: B
Explanation: A) A seizure threshold is not the length of time a seizure will last.
B) Everyone has a seizure threshold. When this threshold is exceeded, a seizure may occur.
C) The presence of convulsions does not determine whether the threshold has been exceeded.
D) A seizure threshold is not a way of classifying seizures as generalized.
Page Ref: 801
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 11.B. Analyze seizure disorders as they relate to intracranial regulation. Compare the risk factors and prevention of seizure disorders.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with seizure disorder.

12) The nurse is preparing a teaching tool about seizure disorders. Which characteristic about seizure triggers should the nurse include?
A) Externalized
B) Generalized
C) Internalized
D) Variable
Answer: D
Explanation: A) A trigger is not externalized if it is an internal condition or internalized if it is an external factor, but different individuals may have different triggers or none at all.
B) General triggers include fatigue, hypoglycemia, fever, alcohol, hyperventilation, and menstruation. Individuals who are able to identify triggers may succeed in reducing their frequency.
C) A trigger is not externalized if it is an internal condition or internalized if it is an external factor, but different individuals may have different triggers, or none at all.
D) Individuals with epilepsy often experience seizure activity upon exposure to a trigger. Triggers may be individualized (e.g., odors, flashing lights). Different individuals may have different triggers, or none at all.
Page Ref: 801
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.B. Analyze seizure disorders as they relate to intracranial regulation. Compare the risk factors and prevention of seizure disorders.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with seizure disorder.

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Exemplar 11.C   Traumatic Brain Injury

1) A client is diagnosed with a traumatic brain injury. Which pathophysiologic reason will the nurse expect to assess in this client for this condition?
A) Congenital disorder
B) External force
C) Infection
D) Stress reaction
Answer: B
Explanation: A) Traumatic injury is not congenital.
B) Traumatic brain injury occurs when an external force causes some degree of impairment to brain structure or function. The damage caused by this external force is referred to as the primary injury.
C) Traumatic brain injury occurs when an external force causes some degree of impairment to brain structure or function. The damage caused by this external force is referred to as the primary injury. Traumatic injury does not follow from an infection.
D) Traumatic injury is not caused by stress.
Page Ref: 812
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.C. Analyze traumatic brain injury as it relates to intracranial regulation. Describe the pathophysiology of traumatic brain injury.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with traumatic brain injury.

2) The nurse is planning teaching on prevention of traumatic brain injury. Which client is least likely to experience this type of injury?
A) A 2-year-old child
B) A 13-year-old adolescent
C) A 44-year-old office worker
D) A 77-year-old retiree
Answer: C
Explanation: A) Children, especially children under the age of 4, are at increased risk for TBI due to falls or abuse.
B) Adolescents and young adults are at increased risk for TBI due to interpersonal violence and sports.
C) The office worker is not in a professional occupation involving a high risk of physical impact and so would not be in a higher-risk group for TBI.
D) Older adults are at increased risk for TBI due to falls, which are usually related to sensory perception changes or medication side effects.
Page Ref: 814
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 11.C. Analyze traumatic brain injury as it relates to intracranial regulation. Compare the risk factors and prevention of traumatic brain injury.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with traumatic brain injury.

3) A client is diagnosed with a mild concussion. Which finding will the nurse expect to assess in this client?
A) Bleeding in the brain
B) Difficulty breathing
C) Acute headache
D) Prolonged unconsciousness
Answer: C
Explanation: A) Bleeding in the brain is associated with a moderate to severe traumatic brain injury.
B) Difficulty breathing is associated with a moderate to severe traumatic brain injury.
C) Acute headache is a clinical manifestation of a mild concussion or traumatic brain injury.
D) Prolonged unconsciousness is associated with a moderate to severe traumatic brain injury.
Page Ref: 814
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.C. Analyze traumatic brain injury as it relates to intracranial regulation. Identify the clinical manifestations of traumatic brain injury.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with traumatic brain injury.

4) The nurse is caring for a client with a traumatic brain injury. For which reason should the nurse expect the client to be evaluated for cerebral edema or ischemia?
A) It often causes a skull fracture.
B) It is an example of a lacerating injury.
C) It is an example of a penetrating injury.
D) It is often secondary to a traumatic brain injury.
Answer: D
Explanation: A) Cerebral edema or ischemia might follow skull fracture but would not cause it.
B) Neither is an example of a lacerating injury.
C) Neither is an example of a penetrating injury.
D) Secondary injuries can be caused by intracranial damage or systemic insults to the brain. Some examples of secondary injuries include cerebral ischemia, cerebral edema, increased intracranial pressure (IICP), infection, hypoxia, hypotension, fever, and hyponatremia.
Page Ref: 813
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 11.C. Analyze traumatic brain injury as it relates to intracranial regulation. Describe the pathophysiology of traumatic brain injury.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with traumatic brain injury.

5) The nurse is creating a teaching tool about traumatic brain injuries. Which types of sports should the nurse include that are most likely to cause this injury?
A) Competitive
B) Energetic
C) High-impact
D) Team
Answer: C
Explanation: A) Competitive sports do not have to be high-impact.
B) Energetic sports do not have to be high-impact.
C) High-impact and extreme sports such as boxing, football, hockey, and skateboarding carry a higher risk of concussion and TBI.
D) Team sports might be competitive and energetic without being high impact.
Page Ref: 814
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 11.C. Analyze traumatic brain injury as it relates to intracranial regulation. Describe the etiology of traumatic brain injury.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with traumatic brain injury.

6) A client is classified as Grade 4 for risk of cerebral vasospasm because of intracerebral clotting and absence of blood in the basal cisterns. Which diagnostic test should the nurse expect to be prescribed to assess intracerebral hemorrhage and grade cerebral vasospasms?
A) Cerebrospinal fluid (CSF) analysis
B) CT scan
C) MRI
D) Transcranial Doppler
Answer: D
Explanation: A) Any clear fluid that leaks from the client's nose or ears should be assessed for CSF (glucose will be present) because this may be indicative of a basilar skull fracture.
B) A CT scan is vital to the diagnosis of traumatic brain injury (TBI) because it can detect the presence and location of skull fractures, contusions, hematomas, hemorrhage, and other brain damage.
C) MRI scans are beneficial for providing more detailed brain images, including axonal injury, once the client is stabilized.
D) Transcranial Doppler may be indicated for intracerebral hemorrhage and is especially useful with grading cerebral vasospasms that may accompany a subarachnoid hemorrhage.
Page Ref: 817
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 11.C. Analyze traumatic brain injury as it relates to intracranial regulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with traumatic brain injury.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with traumatic brain injury.

7) The nurse is reviewing the types of injuries in infants caused by abuse. Which traumatic brain injury (TBI) is least caused by child abuse?

A) Contusion sustained from fall from high chair

B) Contusion, unknown cause

C) Diffuse axonal injury following involvement as passenger in a vehicle collision

D) Diffuse axonal injury, unknown cause

Answer: C

Explanation: A) The fall from a high chair could have happened accidentally or have been caused to happen, and either a contusion or a diffuse axonal injury could be the result of abuse.

B) A toddler who suffers a fall may have a local contusion with edema from a coup-contrecoup injury.

C) A diffuse axonal injury following involvement in a vehicle collision, however, is most likely the result of the collision.

D) An infant who suffers a TBI from shaken baby syndrome will exhibit diffuse axonal injury.

Page Ref: 818

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 11.C. Analyze traumatic brain injury as it relates to intracranial regulation. Differentiate care of patients with traumatic brain injury across the lifespan.

MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with traumatic brain injury.

8) The school nurse is teaching a group of adolescent athletes about reducing the risk for sustaining traumatic brain injuries (TBI). Which information should the nurse include in the teaching session?
A) "A fall from even a low height can cause traumatic brain injury."
B) "A traumatic brain injury can occur to anyone from a wide range of causes."
C) "If you are injured in a game or practice, don't play through the pain."
D) "Wearing seat belts can protect against injuries in motor vehicle collisions."
Answer: C
Explanation: A) A fall does not specifically address the prevention challenges for TBIs that adolescents present.
B) Explaining that traumatic brain injuries can occur to anyone from a wide range of causes does not specifically address the prevention challenges for TBIs that adolescents present.
C) Adolescents often downplay their injuries or do not report them for fear of looking weak or being unable to participate in sports and other activities. This greatly increases their risk of being injured again and developing second impact syndrome, which can be fatal.
D) Wearing seat belts does not specifically address the prevention challenges for TBIs that adolescents present.
Page Ref: 818
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 11.C. Analyze traumatic brain injury as it relates to intracranial regulation. Differentiate care of patients with traumatic brain injury across the lifespan.
MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with traumatic brain injury.

9) A client presents with a mild concussion following a fall. Which problem is least likely applicable for this client?
A) Acute pain
B) Acute confusion
C) Nausea
D) Risk for post-trauma syndrome
Answer: D
Explanation: A) A client with a mild concussion following a fall might present with acute pain.
B) A client with a mild concussion following a fall might present with acute confusion.
C) A client with a mild concussion following a fall might present with nausea.
D) A client with a mild concussion following a fall is not likely to experience post trauma syndrome.
Page Ref: 820
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 11.C. Analyze traumatic brain injury as it relates to intracranial regulation. Apply the nursing process in providing culturally competent care to an individual with traumatic brain injury.

MNL LO: Demonstrate understanding of the concept of intracranial regulation in the care of a patient with traumatic brain injury.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e **(Pearson)**

Module 12 Metabolism

The Concept of Metabolism

1) The nurse is assessing a client. Which findings indicate a potential problem related to adrenal medulla function? **Select all that apply.**
A) Heart rate of 104
B) Weight decreased 10 lb since previous appointment
C) Respiratory rate of 22
D) Dry and cracked heels
E) Blood pressure of 132/84
Answer: A, B, C, E
Explanation: A) The adrenal medulla secretes the catecholamines epinephrine and norepinephrine. These hormones stimulate the heart.
B) The adrenal medulla secretes the catecholamines epinephrine and norepinephrine. These hormones increase metabolism.
C) The adrenal medulla secretes the catecholamines epinephrine and norepinephrine. These hormones increase respiration.
D) Dry and cracked heels are not caused by changes in adrenal medulla function.
E) The adrenal medulla secretes the catecholamines epinephrine and norepinephrine. These hormones constrict blood vessels which affects blood pressure.
Page Ref: 828
Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.1. Analyze the physiology of metabolism in the body.
MNL LO: Analyze the concept of metabolism and its application to nursing care.

2) The nurse is assessing the vital signs of a client experiencing hypoparathyroidism. While monitoring the blood pressure, the nurse notes the client's hand begins to spasm. Which term is appropriate for the nurse to use when documenting this assessment finding?
A) Trousseau sign
B) Chvostek sign
C) Turner sign
D) Cullen sign
Answer: A
Explanation: A) Trousseau sign is elicited when placing a blood pressure cuff on the arm; when the cuff is inflated, the client experiences carpal spasms.
B) Chvostek sign is elicited by tapping on the face in front of the ear and observing for contractions of the muscle.
C) Turner sign is associated with retroperitoneal bleeding.
D) Cullen sign is associated with retroperitoneal bleeding.
Page Ref: 842
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.5. Differentiate common assessment procedures and tests used to examine metabolism.
MNL LO: Analyze the concept of metabolism and its application to nursing care.

3) While performing an endocrine assessment on a client suspected of having an endocrine disorder, the nurse asks if the client has experienced recent weight changes. On which endocrine glands will the nurse focus an assessment because of being related to weight changes? **Select all that apply.**
A) Gonads
B) Pituitary
C) Thyroid
D) Adrenal
E) Parathyroid
Answer: B, C, D
Explanation: A) The gonads influence estrogen and androgens.
B) The client might gain weight with a pituitary disorder. The pituitary gland controls antidiuretic hormone (ADH), which influences water absorption by the renal tubules.
C) The client might gain weight with thyroid disease such as hypothyroidism or hyperthyroidism.
D) The client might gain weight with an adrenal disorder such as Cushing disease.
E) The parathyroid gland regulates calcium and phosphorus.
Page Ref: 827, 831, 833
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.2. Differentiate alterations in metabolism.
MNL LO: Analyze the concept of metabolism and its application to nursing care.

4) The nurse is reviewing the laboratory test results for a client with an endocrine disorder. Which diagnostic tests would the nurse anticipate reviewing for this client? **Select all that apply.**

A) Prothrombin time
B) Serum albumin
C) Ammonia level
D) Liver enzymes
E) T3 and T4 levels

Answer: B, D, E

Explanation: A) Prothrombin time does not specifically assess the structure and function of the endocrine glands.

B) Specific diagnostic tests to assess the structure and function of the glands of the endocrine system include serum albumin.

C) Serum ammonia does not assess the structure and function of the endocrine glands.

D) Specific diagnostic tests to assess the structure and function of the glands of the endocrine system include liver enzymes such as AST, ALT, SGOT, and LDH.

E) Specific diagnostic tests to assess the structure and function of the glands of the endocrine system include thyroid hormones (T3 and T4).

Page Ref: 842

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 12.5. Differentiate common assessment procedures and tests used to examine metabolism.

MNL LO: Analyze the concept of metabolism and its application to nursing care.

5) An older client is diagnosed with disorders of fat metabolism, reduced absorption of fat-soluble vitamins, and a slightly elevated blood glucose level. Which endocrine organ does the nurse consider that contributes to reduced absorption of fat-soluble vitamins as a normal age-related change?

A) Pituitary
B) Thyroid
C) Pancreas
D) Adrenal medulla

Answer: C

Explanation: A) There is no evidence to support focusing on the pituitary gland.
B) There is no evidence to support focusing on the thyroid gland.
C) Normal age-related changes in pancreatic function include decreased production of lipase, which causes less fat absorption and decreased absorption of fat-soluble vitamins. The pancreas also has decreased insulin release and decreased sensitivity to circulating insulin, which can cause an increase in blood glucose levels in the older adult who does not have diabetes.
D) There is no evidence to support focusing on the adrenal medulla.

Page Ref: 847
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 12.8. Differentiate considerations related to the assessment and care of patients with alterations in metabolism throughout the lifespan.
MNL LO: Analyze the concept of metabolism and its application to nursing care.

6) For clients with a deficiency in any hormone, which teaching is important for the nurse to provide?
A) Increasing fluid intake
B) Decreasing body weight
C) Taking hormone supplements as directed
D) Regulating sugar intake
Answer: C
Explanation: A) Depending on the hormone deficiency, clients may need education related to either increasing or decreasing fluid intake.
B) Depending on the hormone deficiency, clients may need education related to either increasing or decreasing body weight.
C) Clients who have a hormone deficiency require client teaching related to the importance of regularly taking their hormone supplements.
D) Client teaching related to regulating sugar intake is specific for clients with insulin deficiency or insulin resistance, not for any client with a hormone deficiency.
Page Ref: 836
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 12.4. Explain the promotion of healthy metabolism.
MNL LO: Analyze the concept of metabolism and its application to nursing care.

WwW.TeSM.Ws

7) Which intervention can the nurse implement independently to provide support to clients with an alteration in metabolism?
A) Administer hormone therapies.
B) Refer the client to a nutritionist.
C) Order blood tests.
D) Refer the client to an acupuncturist.
Answer: B
Explanation: A) Administering hormone therapies is a collaborative intervention.
B) Many clients with an alteration in metabolism will have special dietary needs, so the nurse can refer the client to a nutritionist or dietitian as an independent nursing intervention.
C) Ordering blood tests is outside the scope of nursing practice.
D) Nurses should not refer the client to an acupuncturist without consulting with a provider who understands the effects of acupuncture on the client's specific metabolic disorder.
Page Ref: 842
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 12.6. Analyze independent interventions nurses can implement for patients with alterations in metabolism.
MNL LO: Analyze the concept of metabolism and its application to nursing care.

8) An alteration in calcium regulation and parathyroid hormone levels is likely to directly affect which other nursing concept related to metabolism?
A) Acid-base balance
B) Reproduction
C) Perfusion
D) Mobility
Answer: D
Explanation: A) Acid-base balance is not directly related to calcium regulation and parathyroid hormone levels.
B) Reproduction is not directly related to calcium regulation and parathyroid hormone levels.
C) Perfusion is not directly related to calcium regulation and parathyroid hormone levels.
D) Mobility and the risk for bone fracture is related to calcium regulation, which is controlled by parathyroid hormone and calcitonin.
Page Ref: 836
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 12.3. Outline the relationship between metabolism and other concepts.
MNL LO: Analyze the concept of metabolism and its application to nursing care.

9) Which endocrine gland disorder could result in an increase in growth of the bones, organs, and muscles?
A) Pituitary gland
B) Thyroid gland
C) Parathyroid glands
D) Adrenal glands
Answer: A
Explanation: A) The pituitary gland is responsible for the secretion of growth hormone. Excess growth hormone secretion can result in gigantism in children, which causes an increase in the growth of the bones, organs, and muscles.
B) The thyroid gland does not secrete growth hormone.
C) The parathyroid glands do not secrete growth hormone.
D) The adrenal glands do not secrete growth hormone.
Page Ref: 827
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.2. Differentiate alterations in metabolism.
MNL LO: Analyze the concept of metabolism and its application to nursing care.

10) A pregnant client was diagnosed with hypothyroidism after the birth of a previous child. Which special considerations should the nurse include when caring for this client?
A) The client may need a change in the dosage of levothyroxine (Synthroid).
B) The client is at higher risk for gestational diabetes.
C) The client may need to add a folic acid supplement to the medication regimen.
D) The client is at higher risk for diabetes insipidus.

Answer: A
Explanation: A) Pregnant clients with preexisting endocrine disorders such as hypothyroidism may need a change in the dosage of hormone replacement therapy during the pregnancy. The nurse should consult with the provider to determine what dose is appropriate for the client.
B) Hypothyroidism does not increase the risk for gestational diabetes.
C) The current recommendation is that all pregnant clients take a folic acid supplement to reduce the risk of neural tube defects.
D) Hypothyroidism does not increase the risk for diabetes insipidus.
Page Ref: 846
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 12.8. Differentiate considerations related to the assessment and care of patients with alterations in metabolism throughout the lifespan.
MNL LO: Analyze the concept of metabolism and its application to nursing care.

Exemplar 12.A Type 1 Diabetes Mellitus

1) The nurse is planning care for a client admitted with diabetic ketoacidosis (DKA). On which actions should the nurse focus for this client's care? **Select all that apply.**
A) Administration of oral glucose
B) Monitoring for fluid volume overload
C) Frequent blood glucose monitoring
D) Intravenous fluid infusions
E) Insulin infusion
Answer: C, D, E
Explanation: A) Oral glucose should not be administered to the client with diabetic ketoacidosis.
B) The client will be dehydrated and most likely will not need treatment for fluid volume overload.
C) For the client experiencing diabetic ketoacidosis, frequent blood sugar monitoring mandates that the client be cared for in an intensive care environment until stabilized.
D) For the client experiencing diabetic ketoacidosis, IV fluids mandate that the client be cared for in an intensive care environment until stabilized.
E) For the client experiencing diabetic ketoacidosis, insulin infusion for treatment mandates that the client be cared for in an intensive care environment until stabilized.
Page Ref: 854
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 12.A. Analyze type 1 diabetes mellitus as it relates to metabolism. Identify the clinical manifestations of type 1 diabetes.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 1 diabetes mellitus.

2) The parent of a 4-year-old child newly diagnosed with type 1 diabetes mellitus is concerned about the child's care needs because of having other children at home who need attention. Which problem should the nurse include when planning this client's care?
A) Anxiety
B) Risk for inadequate coping skills
C) Risk for unstable blood glucose level
D) Ready to improve health maintenance
Answer: B
Explanation: A) There is no evidence that the parent or the client are demonstrating anxiety.
B) The parent is concerned about the client's needs in addition to those of other children. The parent is at risk for inadequate coping with the situation.
C) There is not enough information to determine the status of the client's glucose levels.
D) The client is not demonstrating behaviors that indicate a readiness to improve health maintenance.
Page Ref: 871
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 12.A. Analyze type 1 diabetes mellitus as it relates to metabolism. Apply the nursing process in providing culturally competent care to an individual with type 1 diabetes.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 1 diabetes mellitus.

3) The nurse is finalizing a plan of care for a school-age client newly diagnosed with type 1 diabetes mellitus. Which areas should the plan prioritize to achieve the maximum outcomes for this client? **Select all that apply.**
A) Ways to minimize the number of school days missed
B) Identification and referral to community resources
C) Physical activities that limit exposure to injuries
D) Self-management of glucose monitoring and medications
E) Signs and symptoms of hypoglycemia and actions to take
Answer: B, D, E
Explanation: A) Minimizing the number of school days missed is not an immediate priority for this client's plan.
B) Before discharge, the child and the family should be linked to the resources in the community that will support care of the child with diabetes.
C) Activities that limit exposure to injuries is not an immediate priority for this client's plan.
D) Planning should prepare the child and the family for self-management of glucose monitoring. and medications.
E) Planning should prepare the child and the family for signs and symptoms of hypoglycemia, and actions to take.
Page Ref: 859-861
Cognitive Level: Creating
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care | Nursing Process: Planning
Learning Outcome: 12.A. Analyze type 1 diabetes mellitus as it relates to metabolism. Apply the nursing process in providing culturally competent care to an individual with type 1 diabetes.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 1 diabetes mellitus.

4) The nurse is providing care to a client who is receiving treatment for diabetic ketoacidosis (DKA). Which possible pathophysiologic cause should the nurse identify for the altered metabolism the client is experiencing?
A) Insulin deficiency
B) Decreased gluconeogenesis
C) Excess production of bicarbonate
D) Hypo-osmolarity
Answer: A
Explanation: A) A client who is diagnosed with DKA will experience alterations in metabolism due to an insulin deficiency.
B) Within the pathophysiology of diabetic ketoacidosis, the client will experience increased gluconeogenesis.
C) Within the pathophysiology of diabetic ketoacidosis, the client will experience a loss of bicarbonate.
D) Within the pathophysiology of diabetic ketoacidosis, the client will experience hyperosmolarity.
Page Ref: 853
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.A. Analyze type 1 diabetes mellitus as it relates to metabolism. Identify the clinical manifestations of type 1 diabetes.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 1 diabetes mellitus.

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5) The client with diabetes mellitus reports having difficulty trimming the toenails because they are thick and ingrown. Which recommendation should the nurse make to this client?
A) Make an appointment with a podiatrist.
B) Offer to file the tops of the nails to reduce thickness after cutting.
C) Cut the nails straight across with a clipper after the bath.
D) Make an appointment with a nail shop for a pedicure.
Answer: A
Explanation: A) The toenails of the client with diabetes require close care. If the nails are thick or ingrown, they require the attention of a podiatrist.
B) The nurse should not file the client's toenails to reduce thickness.
C) Cutting the nails across after the bath is correct for toenails that do not demonstrate the complications listed.
D) The client with diabetes is at an increased risk for infection and should avoid situations in which this risk is increased, such as the nail shop pedicure.
Page Ref: 859
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 12.A. Analyze type 1 diabetes mellitus as it relates to metabolism. Apply the nursing process in providing culturally competent care to an individual with type 1 diabetes.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 1 diabetes mellitus.

6) A client who is newly diagnosed with type 1 diabetes has smoked for 30 years. Which information should the nurse explain about the effects of smoking and diabetes?
A) Contributes to the development of diabetic neuropathy.
B) Increases insulin resistance.
C) Accelerates atherosclerotic changes in blood vessels.
D) Promotes weight gain.
Answer: C
Explanation: A) Poor glycemic control in diabetics is associated with the development of complications including diabetic neuropathy.
B) Smoking does not affect insulin resistance.
C) Smoking is especially unhealthy for diabetic clients because smoking accelerates the atherosclerotic effects that occur in blood vessels from elevated levels of blood glucose.
D) Smoking is not associated with weight gain; in fact, people use weight gain as an excuse not to quit smoking.
Page Ref: 856
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 12.A. Analyze type 1 diabetes mellitus as it relates to metabolism. Apply the nursing process in providing culturally competent care to an individual with type 1 diabetes.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 1 diabetes mellitus.

WW.TBSM.WS

7) A client newly diagnosed with type 1 diabetes mellitus tells the nurse that the diagnosis must be wrong because the client is not overweight, eats all of the time, and is thin. Which response by the nurse is most appropriate?
A) "Thin people can be diabetic, too."
B) "Your condition makes it impossible for you to gain weight."
C) "Your laboratory tests indicate the presence of diabetes."
D) "You are eating large quantities because your condition makes it difficult for your body to obtain energy from the foods taken in."
Answer: D
Explanation: A) While the statement about diabetics being thin is correct, it does not answer the client.
B) It is not impossible for people with diabetes to gain weight.
C) Although the laboratory tests might indicate the presence of diabetes, this does not meet the client's needs for teaching.
D) The client with diabetes is unable to obtain the needed glucose for the body's cells due to the lack of insulin. Clients diagnosed with type 1 diabetes mellitus experience polyphagia and are often thin.
Page Ref: 850
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 12.A. Analyze type 1 diabetes mellitus as it relates to metabolism. Identify the clinical manifestations of type 1 diabetes.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 1 diabetes mellitus.

WwW.TeSM.Ws

8) The destruction of which types of cells in the islets of Langerhans cause type 1 diabetes mellitus?

A) Alpha cells
B) Beta cells
C) Delta cells
D) Gamma cells

Answer: B

Explanation: A) Alpha cells are responsible for the production of glucagon.

B) The beta cells of the islets of Langerhans in the pancreas are the only cells in the body that produce insulin. Destruction of these cells cause type 1 diabetes mellitus.

C) Delta cells produce somatostatin.

D) Gamma cells produce pancreatic polypeptide.

Page Ref: 850

Cognitive Level: Remembering

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 12.A. Analyze type 1 diabetes mellitus as it relates to metabolism. Describe the pathophysiology of type 1 diabetes.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 1 diabetes mellitus.

9) Which health promotion and prevention information should the nurse provide about type 1 diabetes?
A) Teaching clients at high risk how to prevent type 1 diabetes
B) Teaching clients with type 1 diabetes how to prevent complications
C) Providing clients with vaccinations against viruses that cause type 1 diabetes
D) Referring clients to a nutritionist and exercise therapist
Answer: B
Explanation: A) Currently, there is no known way to prevent type 1 diabetes.
B) Teaching related to type 1 diabetes should focus on preventing the short- and long-term complications of the disease process.
C) There is no evidence to support a specific virus as causing type 1 diabetes.
D) Nurses may refer clients to a nutritionist or exercise therapist after diagnosis, but proper nutrition or exercise will not prevent type 1 diabetes.
Page Ref: 850
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | Nursing Process: Implementation
Learning Outcome: 12.A. Analyze type 1 diabetes mellitus as it relates to metabolism. Compare the risk factors and prevention of type 1 diabetes.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 1 diabetes mellitus.

10) A client diagnosed with type 1 diabetes since childhood plans to conceive. Which examination should the nurse prepare the woman to have before, during, and after the pregnancy?
A) Gastrointestinal examination for gastric hypotony
B) Neurologic examination for diabetic peripheral neuropathy
C) Eye examination for diabetic retinopathy
D) Renal examination for urinary incontinence
Answer: C
Explanation: A) Older adults are at increased risk for gastric hypotony.
B) Pregnant women with type 1 diabetes are not at increased risk for diabetic peripheral neuropathy compared to other clients with type 1 diabetes.
C) Pregnant women with type 1 diabetes are at an increased risk for diabetic retinopathy. Women with type 1 diabetes who are planning a pregnancy should have eye examinations before the pregnancy, during each trimester, and for 1 year postpartum.
D) Older adults are at increased risk for urinary incontinence related to type 1 diabetes.
Page Ref: 870
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 12.A. Analyze type 1 diabetes mellitus as it relates to metabolism. Differentiate care of patients with type 1 diabetes across the lifespan.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 1 diabetes mellitus.

Exemplar 12.B Type 2 Diabetes Mellitus

1) An older adult client is having a yearly physical examination. Which client statement would indicate a possible diagnosis of diabetes mellitus?
A) "I'm slightly winded when I walk up a flight of stairs, but it passes quickly."
B) "I feel a bit tired by mid-afternoon and take a 30-minute nap most days."
C) "I sometimes have muscle aches in my upper legs at night."
D) "I've been experiencing increased thirst during the past several months."
Answer: D
Explanation: A) Being slightly short of breath after walking up a flight of stairs with a quick recovery may be within the normal functioning of a healthy older client.
B) Fatigue that responds to a short nap may be within the normal functioning of a healthy older client.
C) Having some muscle aches at night may be within the normal functioning of a healthy older client.
D) Excessive thirst can be associated with high glucose levels and may be a symptom of undiagnosed diabetes mellitus.
Page Ref: 877
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 12.B. Analyze type 2 diabetes mellitus as it relates to metabolism. Identify the clinical manifestations of type 2 diabetes.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 2 diabetes mellitus.

2) The nurse is asked why weight loss reduces the risk of developing type 2 diabetes. Which response by the nurse is most appropriate?

A) "Excess body weight impairs the body's release of insulin."

B) "The amount of food taken in by those who are overweight requires more insulin to adequately metabolize, resulting in diabetes."

C) "The physical inactivity associated with obesity causes a reduced ability by the body to produce insulin."

D) "Thin people are less likely to become diabetic."

Answer: A

Explanation: A) Beta cells of the body release insulin. Their actions are hindered as the amount of adipose tissue in the body increases.

B) The amount of food taken in is not the issue as much as the excess body weight. The body does require more insulin with a greater food intake, but that does not necessarily result in diabetes.

C) Inactivity is directly linked to obesity, but it does not present a direct tie to the production of insulin.

D) Thin people can develop type 2 diabetes.

Page Ref: 877

Cognitive Level: Applying

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 12.B. Analyze type 2 diabetes mellitus as it relates to metabolism. Compare the risk factors and prevention of type 2 diabetes.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 2 diabetes mellitus.

3) The nurse is planning care for a client with type 2 diabetes mellitus. Which problem would be most appropriate for this client?
A) Inability to provide self-care
B) Potential for impaired tissue integrity
C) Inefficient cardiac perfusion
D) Resistance to learning about the disease process
Answer: B
Explanation: A) There is no evidence that the client is unable to provide self-care.
B) A client with diabetes mellitus is at risk for complications, one being maintaining tissue integrity. This would be the problem most appropriate for the client.
C) There is no evidence that the client has inefficient cardiac perfusion.
D) There is no evidence that the client is resistant to learning about the disease process.
Page Ref: 884
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 12.B. Analyze type 2 diabetes mellitus as it relates to metabolism. Apply the nursing process in providing culturally competent care to an individual with type 2 diabetes.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 2 diabetes mellitus.

4) The healthcare provider prescribes sitagliptin (Januvia) for a client with type 2 diabetes mellitus. For which potential side effect should the nurse monitor this client?
A) Elevated blood lipid levels
B) Hyperglycemia
C) Pancreatitis
D) Renal insufficiency
Answer: C
Explanation: A) Sitagliptin (Januvia) does not cause elevated blood lipids.
B) Sitagliptin (Januvia) does not cause hyperglycemia.
C) A potential side effect of sitagliptin (Januvia) is pancreatitis, and the client must be monitored for this.
D) Sitagliptin (Januvia) does not cause renal insufficiency.
Page Ref: 839
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.B. Analyze type 2 diabetes mellitus as it relates to metabolism. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with type 2 diabetes.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 2 diabetes mellitus.

5) After reviewing the population demographics for an urban community, the nurse determines that community members would benefit from teaching on type 2 diabetes mellitus in children. Which findings support this nurse's conclusion? **Select all that apply.**

A) A large number of community families have both parents diagnosed with type 2 diabetes mellitus.

B) There is low compliance with the annual flu vaccination.

C) Half of the children in the community are African American.

D) A quarter of the children in the community are Hispanic.

E) Most of the children are raised in families where both parents are unemployed.

Answer: A, C, D

Explanation: A) The risk factors for diabetes include having parents with the condition.

B) Frequency of obtaining the annual flu vaccination is not a risk factor for the development of type 2 diabetes in children.

C) Type 2 diabetes is higher in those of the African American population.

D) Type 2 diabetes is high in those of the Hispanic population.

E) Socioeconomic status is not a risk factor for the development of type 2 diabetes in children.

Page Ref: 877

Cognitive Level: Analyzing

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 12.B. Analyze type 2 diabetes mellitus as it relates to metabolism. Compare the risk factors and prevention of type 2 diabetes.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 2 diabetes mellitus.

6) What collaborative interventions are likely to improve outcomes for an 11-year-old client diagnosed with type 2 diabetes mellitus? **Select all that apply.**
A) Weaning off oral medications
B) Food intake based on age, sex, and physical activity
C) Obtaining adequate rest and sleep
D) Physical activity to be at least 30 to 60 minutes per day most days of the week
E) Family participation in the lifestyle change
Answer: B, D, E
Explanation: A) The child with type 2 diabetes mellitus will most likely be treated with oral hypoglycemic agents. Weaning off of these medications will not improve the client's long-term prognosis.
B) Plans to improve the client's long-term prognosis should focus on food intake that is based on the client's age, sex, and physical activity.
C) The child with type 2 diabetes mellitus does not have a need for adequate rest and sleep to improve the long-term prognosis.
D) Plans to improve the client's long-term prognosis should focus on obtaining the required physical activity that is recommended for most days of the week.
E) Plans to improve the client's long-term prognosis should focus on family support to comply with lifestyle changes that the client needs.
Page Ref: 882
Cognitive Level: Creating
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 12.B. Analyze type 2 diabetes mellitus as it relates to metabolism. Differentiate care of patients with type 2 diabetes across the lifespan.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 2 diabetes mellitus.

7) Which pathophysiologic process causes type 2 diabetes?
A) Excessive insulin production
B) Insulin resistance
C) Inability of the pancreas to produce insulin
D) Impaired insulin uptake
Answer: B
Explanation: A) The level of insulin produced in type 2 diabetes varies; production could be increased or decreased, depending on the client.
B) Type 2 diabetes occurs despite the availability of endogenous insulin, because insulin's functioning is impaired by insulin resistance.
C) The pancreas is able to produce insulin, but the insulin cannot work properly due to insulin resistance.
D) Glucose uptake, not insulin uptake, is impaired in type 2 diabetes.
Page Ref: 877
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.B. Analyze type 2 diabetes mellitus as it relates to metabolism. Describe the pathophysiology of type 2 diabetes.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 2 diabetes mellitus.

8) Which potential cause of type 2 diabetes influences insulin's ability to regulate glucose metabolism and uptake by the liver, skeletal muscles, and adipose tissue?
A) Infections
B) Exposure to toxins
C) Young age
D) Obesity
Answer: D
Explanation: A) Infections are known triggers for type 1 diabetes, not type 2 diabetes.
B) Chemical toxins are known triggers for type 1 diabetes, not type 2 diabetes.
C) Older age, not young age, can increase cellular resistance to the effects of insulin and increase the risk of developing type 2 diabetes.
D) In obesity, insulin has a decreased ability to influence glucose metabolism and uptake by the liver, skeletal muscles, and adipose tissue.
Page Ref: 877
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.B. Analyze type 2 diabetes mellitus as it relates to metabolism. Describe the etiology of type 2 diabetes.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 2 diabetes mellitus.

9) Which test is commonly used to screen for type 2 diabetes in the general population?
A) Fasting plasma glucose
B) Oral glucose tolerance test
C) Urine ketone levels
D) Serum cholesterol levels
Answer: A
Explanation: A) Tests used to screen for type 2 diabetes in the general population include fasting plasma glucose and glycated hemoglobin (A1C).
B) Oral glucose tolerance tests are primarily used for screening for gestational diabetes in pregnant women, although they can also be used for clients with suspected diabetes.
C) Urine ketone levels and serum cholesterol levels are not used for screening. Urine ketone levels are used primarily to monitor clients with type 1 diabetes.
D) Serum cholesterol levels are measured to assess the risk for cardiovascular disease, which may or may not be related to diabetes.
Page Ref: 879
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 12.B. Analyze type 2 diabetes mellitus as it relates to metabolism. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with type 2 diabetes.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 2 diabetes mellitus.

10) Which goal would be most appropriate to include in the nursing care plan of a client with type 2 diabetes?
A) The client will record daily fat intake.
B) The client will use hand hygiene when toileting.
C) The client will monitor fasting glucose levels.
D) The client will inspect feet at least once daily.
Answer: D

Explanation: A) Clients with type 2 diabetes should record carbohydrate intake, not fat intake.

B) Teaching proper hand hygiene may be appropriate when teaching clients with diabetes about insulin injections, but teaching hand hygiene when toileting is not specific for clients with type 2 diabetes.

C) Although fasting glucose levels are important, postprandial blood glucose levels provide the most useful information for evaluating glycemic control in clients with type 2 diabetes.

D) Clients with type 2 diabetes are at high risk for foot problems related to diabetic peripheral neuropathy. Therefore, an appropriate goal for clients with type 2 diabetes includes inspecting feet at least once daily.

Page Ref: 884
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 12.B. Analyze type 2 diabetes mellitus as it relates to metabolism. Apply the nursing process in providing culturally competent care to an individual with type 2 diabetes.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 2 diabetes mellitus.

11) The nurse is caring for a 76-year-old client with type 2 diabetes who is recovering from surgery following a hip fracture. In addition to blood glucose level, which assessment finding should the nurse recognize as a sign of hyperosmolar hyperglycemic state (HHS)?

A) Excessive sweating
B) Increased urine output
C) Insomnia
D) Edema

Answer: B

Explanation: A) Excessive sweating is not a symptom of HHS.

B) Older adults with type 2 diabetes who have undergone a major surgery are at high risk for developing hyperosmolar hyperglycemic state (HHS). Symptoms of HHS include greatly elevated blood glucose levels, high plasma osmolarity, and altered level of consciousness. Other symptoms include increased urine output.

C) Lethargy and not insomnia is a symptom of HHS.

D) HHS leads to dehydration and fluid loss, not edema.

Page Ref: 878

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 12.B. Analyze type 2 diabetes mellitus as it relates to metabolism. Differentiate care of patients with type 2 diabetes across the lifespan.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with type 2 diabetes mellitus.

Exemplar 12.C Liver Disease

1) The nurse is concerned that a client with potential hepatic failure is at risk for developing ascites. Which assessment finding supports the development of liver failure as manifested by ascites?
A) Increased abdominal girth
B) Gallbladder pain
C) Yellow-tinged skin
D) Bleeding and bruising easily
Answer: A
Explanation: A) Ascites is the accumulation of the fluid in the abdomen and is a result of liver failure. The client with ascites would have an increased abdominal girth.
B) Obstructed biliary flow could be the cause of gallbladder pain.
C) Jaundice is manifested as yellow-tinged skin and is the result of hepatic disorders.
D) The client experiencing hepatic problems might have bleeding and bruising issues due to inadequate vitamin K.
Page Ref: 886
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.C. Analyze liver disease as it relates to metabolism. Identify the clinical manifestations of liver disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with liver disease.

2) The nurse is caring for a client who complains of jaundice and pruritus. The healthcare provider suspects that the client has liver disease. Which modifiable risk factor for cirrhosis of the liver might the nurse see in the client's history?
A) Smokes two packs of cigarettes per day
B) Drinks a six-pack of beer each evening
C) History of occupational exposure to hepatic toxins
D) Family history of fatty liver disease
Answer: B
Explanation: A) Smoking is a risk factor for lung disease.
B) Risk factors for the development of cirrhosis of the liver include excessive alcohol intake.
C) Past history of exposure to hepatic toxins may contribute to the risk of liver disease but is not a modifiable risk factor.
D) A family history of fatty liver disease is not a modifiable risk factor.
Page Ref: 888
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.C. Analyze liver disease as it relates to metabolism. Compare the risk factors and prevention of liver disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with liver disease.

3) The nurse is caring for a client who was recently admitted for treatment of cirrhosis. The client is currently experiencing ascites, +3 pitting edema, and oliguria. Which problem should the nurse select as a priority for this client?
A) Fluid volume excess
B) Inadequate peripheral tissue perfusion
C) Insufficient volume of fluid
D) Impaired skin integrity
Answer: A
Explanation: A) The client experiencing ascites, edema, and oliguria should have a care plan for the problem of fluid volume excess.
B) Inadequate peripheral tissue perfusion would be the appropriate diagnosis for a client experiencing cyanosis or tissue necrosis.
C) Hypotension and dry mucous membranes are associated with insufficient volume of fluid.
D) Edema can cause impaired tissue integrity, but there is no evidence of such problems with this client.
Page Ref: 894
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 12.C. Analyze liver disease as it relates to metabolism. Apply the nursing process in providing culturally competent care to an individual with liver disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with liver disease.

4) The family member of a client with cirrhosis of the liver asks about portal hypertension. Which symptom should the nurse describe to the family member?
A) Muscle wasting
B) Hypothermia
C) Bleeding gums
D) Hemorrhoids
Answer: D
Explanation: A) Muscle wasting is commonly associated with the poor nutritional intake seen in clients with cirrhosis.
B) Hypothermia is an unrelated finding.
C) Bleeding gums indicate insufficient vitamin K production in the liver.
D) Obstruction to portal blood flow causes a rise in portal venous pressure, resulting in splenomegaly, ascites, and engorgement of veins in the esophagus, rectum, and abdomen.
Page Ref: 887
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 12.C. Analyze liver disease as it relates to metabolism. Identify the clinical manifestations of liver disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with liver disease.

5) The nurse is caring for a client recovering from a liver transplant necessitated by cirrhosis of the liver. Which postoperative outcome would be a priority for this client?
A) Moist membranes of the mouth
B) Normal serum bilirubin levels
C) Ability to move the legs
D) Normal pupil reaction
Answer: B
Explanation: A) Moist mouth membranes is a normal finding in a client recovering from surgery.
B) An indication for liver transplant is increasing bilirubin levels. Normal bilirubin levels after surgery would indicate that the transplanted liver is functioning correctly.
C) Normal leg movement would be expected in a client recovering from surgery.
D) Normal pupil reaction would be expected after surgery.
Page Ref: 891
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 12.C. Analyze liver disease as it relates to metabolism. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with liver disease.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with liver disease.

6) A client with liver cirrhosis begins to drain bright red blood through the nasogastric tube. Which medication should the nurse prepare to administer to this client?
A) Vitamin K
B) Ferrous sulfate
C) Platelets
D) Folic acid
Answer: C
Explanation: A) Vitamin K may be ordered to reduce the risk of bleeding.
B) Ferrous sulfate is used to treat anemia.
C) When bleeding is acute, packed RBCs, fresh frozen plasma, or platelets may be administered to restore blood components and promote hemostasis.
D) Folic acid is used to treat anemia.
Page Ref: 891
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 12.C. Analyze liver disease as it relates to metabolism. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with liver disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with liver disease.

7) The nurse is caring for a client with end-stage liver disease. Which alterations should the nurse anticipate with this client? **Select all that apply.**

A) Elevated serum albumin levels due to increased protein synthesis
B) Decreased clotting factor levels due to impaired clotting factor production
C) Hyperglycemia due to disrupted glucose metabolism
D) Increased serum vitamin K due to impaired clearance of fat-soluble vitamins
E) Increased plasma oncotic pressure due to impaired protein metabolism

Answer: B, C

Explanation: A) Low albumin levels is a finding in end-stage liver disease.
B) Impaired clotting-factor production increases the risk for bleeding.
C) Disrupted glucose metabolism and storage may result in hyperglycemia.
D) Serum vitamin K is decreased due to impaired absorption of fat-soluble vitamins.
E) Low albumin levels contribute to edema in peripheral tissues and ascites (accumulation of fluid in the abdomen), as plasma oncotic pressure is reduced, not increased.

Page Ref: 886

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 12.C. Analyze liver disease as it relates to metabolism. Describe the pathophysiology of liver disease.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with liver disease.

8) A client with liver disease presents to the hospital with severe ascites. Which pathophysiologic changes does the nurse recognize as contributing to the development of ascites? **Select all that apply.**
A) Presence of portal hypertension
B) Presence of hyperalbuminemia
C) Increased colloidal osmotic pressure
D) Sodium and water retention
E) Presence of hypoaldosteronism
Answer: A, D
Explanation: A) Ascites is the accumulation of plasma-rich fluid in the abdominal cavity. Although portal hypertension is the primary cause of ascites, decreased serum proteins and increased aldosterone also contribute to the fluid accumulation.
B) Hypoalbuminemia (low serum albumin) decreases the colloidal osmotic pressure of plasma.
C) Hypoalbuminemia (low serum albumin) decreases the colloidal osmotic pressure of plasma. This pressure normally holds fluid in the intravascular compartment, but when the plasma colloidal osmotic pressure decreases, fluid escapes into extravascular compartments.
D) Hyperaldosteronism (an increase in aldosterone) causes sodium and water retention, contributing to ascites and generalized edema.
E) Hyperaldosteronism occurs and not hypoaldosteronism.
Page Ref: 886
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

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Learning Outcome: 12.C. Analyze liver disease as it relates to metabolism. Identify the clinical manifestations of liver disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with liver disease.

9) Which condition is caused by restricted blood flow through the liver?
A) Portal hypertension
B) Cirrhosis
C) Jaundice
D) Biliary atresia
Answer: A
Explanation: A) Restricted blood flow through the liver results in portal hypertension, or increased pressure in the portal venous system.
B) Cirrhosis results when functional liver tissue is destroyed and replaced by fibrous scar tissue.
C) Jaundice results from impaired bilirubin conversion and excretion.
D) Biliary atresia is a disorder of the bile ducts that causes backup of bile into the liver, resulting in tissue damage.
Page Ref: 888
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.C. Analyze liver disease as it relates to metabolism. Describe the pathophysiology of liver disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with liver disease.

10) When individuals engage in excessive alcohol consumption, which liver function is impacted, leading to subsequent liver damage?
A) Metabolism
B) Synthesis
C) Detoxification
D) Glycogen storage
Answer: C
Explanation: A) Metabolism of proteins is a normal function of the liver that helps maintain health.
B) Synthesis of albumin and clotting factors is a normal function of the liver that helps maintain health.
C) The liver is responsible for detoxifying alcohol and other substances. If an individual participates in high-risk behaviors such as excessive alcohol consumption, the detoxification function of the liver can be overwhelmed, resulting in damage to the liver.
D) Glycogen storage is a normal function of the liver that helps maintain health.
Page Ref: 886
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.5. Examine common barriers to active involvement of patients in their own health care processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment
Learning Outcome: 12.C. Analyze liver disease as it relates to metabolism. Compare the risk factors and prevention of liver disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with liver disease.

11) Which action should the nurse take to decrease pruritus in a client with liver disease?
A) Vigorously scrub the skin with soap to prevent infection.
B) Apply a lubricant on the skin to prevent dry skin.
C) Use hot water rather than cool water when bathing the client.
D) Administer an antihistamine as needed to reduce itching.
Answer: B
Explanation: A) The skin should not be rubbed, and soap or preparations with alcohol should be avoided.
B) Clients with pruritus require nursing interventions aimed at reducing itching and promoting skin integrity. Emollients or lubricants should be applied as needed to keep the skin moist.
C) Warm water should be used rather than hot water when bathing, because hot water increases pruritus.
D) Antihistamines should be used cautiously because decreased liver function could alter drug responses.
Page Ref: 891, 895
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.6. Describe how the strength and relevance of available evidence influences the choice of interventions in provision of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Evidence and best practices for nursing. | Nursing Process: Implementation
Learning Outcome: 12.C. Analyze liver disease as it relates to metabolism. Apply the nursing process in providing culturally competent care to an individual with liver disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with liver disease.

12) A 2-week-old infant develops jaundice and clay-colored stools. Which additional finding indicates to the nurse that the client may have biliary atresia?
A) Above average weight gain
B) Increased urine output
C) Abdominal distention
D) Reduced rooting reflex
Answer: C
Explanation: A) The symptoms would result in below average weight gain rather than above average weight gain.
B) Urine should be assessed for color, not volume.
C) Symptoms of biliary atresia usually appear 2 to 3 weeks after birth. They include jaundice, abdominal distention, white or clay-colored stools with putty-like consistency, tea-colored urine, and failure to thrive.
D) Biliary atresia may cause malnutrition due to poor absorption of nutrients, not a reduced rooting reflex.
Page Ref: 893
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.C. Analyze liver disease as it relates to metabolism. Differentiate care of patients with liver disease across the lifespan.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with liver disease.

13) A school-age child is experiencing severe itching, bruising easily, restlessness, and involuntary jerking of the hands. Which organ or system should the nurse anticipate needing to assess further?
A) Liver
B) Nervous system
C) Gastrointestinal tract
D) Urinary system
Answer: A
Explanation: A) Severe itching (pruritus) is common in children with liver cirrhosis. Bruising easily indicates a decreased clotting ability, which could be related to the inability of the liver to produce clotting factors. Restlessness and involuntary jerking of the hands (asterixis) are both signs of portal systemic encephalopathy. All of these symptoms relate to liver disease, particularly cirrhosis. Therefore, a history of infection or disease with liver involvement will be most important to obtain from this client.
B) Infections or diseases of the nervous system would not produce these symptoms.
C) Infections or diseases of the gastrointestinal tract would not produce these symptoms.
D) Infections or diseases of the urinary system would not produce these symptoms.
Page Ref: 893
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 12.C. Analyze liver disease as it relates to metabolism. Differentiate care of patients with liver disease across the lifespan.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with liver disease.

Exemplar 12.D Osteoporosis

1) The nurse is assessing a client who is postmenopausal. Which question should the nurse ask to assess for signs of osteoporosis?
A) "Have you experienced any palpitations?"
B) "Are you having any low back pain?"
C) "Are you having problems with swelling in your feet?"
D) "Is constipation a problem for you?"
Answer: B
Explanation: A) Palpitations do not occur with osteoporosis.
B) A client with osteoporosis will often present with low back pain as well as a decrease in height.
C) Swelling is not an early sign of osteoporosis.
D) Constipation is not an early sign of osteoporosis.
Page Ref: 899
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.D. Analyze osteoporosis as it relates to metabolism. Identify the clinical manifestations of osteoporosis.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with osteoporosis.

2) The nurse is conducting a health history on an older adult client. Which assessment finding indicates the client is at risk for osteoporosis?
A) Having a body mass index (BMI) that indicates obesity
B) Using corticosteroids for 10 years because of a chronic lung disorder
C) Eating three to five servings of shrimp and liver per week
D) Drinking three glasses of skim milk daily
Answer: B
Explanation: A) Obesity is not a risk factor for osteoporosis.
B) Long-time use of corticosteroids is a risk factor for developing osteoporosis.
C) A diet rich in shellfish and organ meats is high in purine, which may predispose the client to gout.
D) Skim milk is a good source of calcium and vitamin D, which prevents or slows osteoporosis.
Page Ref: 898
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.D. Analyze osteoporosis as it relates to metabolism. Compare the risk factors and prevention of osteoporosis.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with osteoporosis.

3) The nurse is planning care for a female adult client who is high-risk for developing osteoporosis. Which interventions will decrease the client's risk of developing this health problem? **Select all that apply.**

A) Increasing the intake of alcoholic beverages
B) Isometric exercise for at least 30 minutes three times per week
C) Weight-bearing exercises such as walking
D) Having a yearly dual-energy x-ray absorptiometry (DEXA) test
E) A diet with adequate amounts of calcium and vitamin D

Answer: C, E

Explanation: A) Measures to prevent or treat osteoporosis include limiting the intake of beverages containing alcohol.

B) Isometric exercises are not effective against osteoporosis.

C) Interventions that may decrease this client's risk of developing osteoporosis include regular weight-bearing exercise, such as walking, as this activity slows bone loss.

D) A DEXA test measures bone density, but it does not decrease the client's risk for developing osteoporosis.

E) Interventions that may decrease this client's risk of developing osteoporosis include encouraging clients to consume adequate amounts of calcium and vitamin D in their diets to prevent osteoporotic fracture.

Page Ref: 898-899

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

WwW.TeSt.Ws

Learning Outcome: 12.D. Analyze osteoporosis as it relates to metabolism. Compare the risk factors and prevention of osteoporosis.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with osteoporosis.

4) The nurse identifies the problem of inadequate nutrition for a client with osteoporosis. Which client statement indicated to the nurse that this problem was appropriate?
A) "I like to remove all of the fat from the meat I eat."
B) "I am trying to eat a low-carb diet."
C) "I plan to start eating out less."
D) "I am allergic to dairy products."
Answer: D
Explanation: A) Removing fat from meat helps reduce caloric intake but does not address the root cause of osteoporosis.
B) Eating a low-carb diet helps reduce caloric intake but does not address the root cause of osteoporosis.
C) Eating out less helps reduce caloric intake but does not address the root cause of osteoporosis.
D) The client who is allergic to dairy products may not take in much calcium, which increases the risk of osteoporosis, so focusing on diet would be a priority for this client.
Page Ref: 903
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 12.D. Analyze osteoporosis as it relates to metabolism. Apply the nursing process in providing culturally competent care to an individual with osteoporosis.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with osteoporosis.

5) A client asks what can be done to decrease the risk of actually developing osteoporosis. Which intervention would be the most beneficial for this client?
A) Decreasing the amount of calcium in the client's diet
B) Providing the client with assisted range of motion exercising twice daily
C) Increasing regular weight-bearing activities
D) Protecting the client's bones with strict bedrest
Answer: C
Explanation: A) Decreasing calcium intake may potentiate the development of osteoporosis.
B) Assisted range of motion exercises may potentiate the development of osteoporosis.
C) A standard intervention for those attempting to prevent osteoporosis is beginning an exercise plan that includes weight-bearing activities.
D) Strict bedrest may potentiate the development of osteoporosis.
Page Ref: 899
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 12.D. Analyze osteoporosis as it relates to metabolism. Compare the risk factors and prevention of osteoporosis.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with osteoporosis.

6) An adult client with osteoporosis resides in a long-term care facility and has a history of falls and dementia. Which nursing intervention would the nurse take to prevent an injury in this client?
A) Using furniture as obstacles to keep the client in the bed
B) Keeping the bed in the lowest position
C) Keeping a nightlight on in the hallway
D) The use of wrist restraints
Answer: B
Explanation: A) Using the furniture as an obstacle could cause injury if the client is able to get up.
B) Keeping the bed in the lowest position will reduce the incidence of injury should the client attempt to get up.
C) In a long-term care facility, a nightlight should be provided in the room so the client can see to use the restroom.
D) The use of restraints could increase the incidence of injury.
Page Ref: 903
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 12.D. Analyze osteoporosis as it relates to metabolism. Apply the nursing process in providing culturally competent care to an individual with osteoporosis.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with osteoporosis.

7) The nurse is providing teaching to a young adult who is at risk for early-onset osteoporosis. Which intervention should the nurse suggest?
A) Stop all physical activity.
B) Reduce the intake of dairy in the diet.
C) Increase intake of calcium and vitamin D.
D) Start estrogen replacement therapy.
Answer: C
Explanation: A) Walking and weight-bearing exercise help prevent osteoporosis, so the client should not stop all physical activity.
B) Dairy is rich in calcium, so reducing intake of dairy is not recommended.
C) An appropriate action for this client is a diet rich in calcium and vitamin D.
D) Due to the client's age, it is not likely that the client needs estrogen replacement therapy at this time.
Page Ref: 898
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 12.D. Analyze osteoporosis as it relates to metabolism. Compare the risk factors and prevention of osteoporosis.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with osteoporosis.

8) A client who is postmenopausal is concerned about the development of osteoporosis and wants to begin preventative activities. Which statement by the nurse is appropriate?
A) "You should first determine if you are at risk for the development of osteoporosis."
B) "After menopause, the decline is too rapid to begin preventative interventions."
C) "Weight-bearing exercise and calcium supplements are helpful in the prevention of osteoporosis."
D) "Hormone replacement therapy should be initiated as soon as possible."
Answer: C
Explanation: A) Although a full analysis would be beneficial, it does not answer the client's request for information.
B) It is not too late to begin prevention activities.
C) Osteoporosis risk factors increase after menopause. Preventative activities include implementing weight-bearing exercise and beginning calcium supplements.
D) Without additional information, it is not possible to determine if the client is a candidate for hormone replacement therapy.
Page Ref: 898
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 12.D. Analyze osteoporosis as it relates to metabolism. Compare the risk factors and prevention of osteoporosis.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with osteoporosis.

9) The nurse is caring for an older adult client who is taking calcium for the treatment of osteoporosis. Which statements will the nurse include when educating the client about this medication? **Select all that apply.**
A) "The most common adverse effect is hypercalcemia caused by taking too much of the supplement."
B) "Oral calcium supplements are best taken on an empty stomach."
C) "Adults 50 years of age and over should obtain at least 500 to 750 mg per day of elemental calcium."
D) "If you have a condition called ventricular fibrillation, this medication might help."
E) "Report symptoms of weakness, increased urination, and thirst."
Answer: A, E
Explanation: A) The most common adverse effect is hypercalcemia caused by taking too much of the supplement.
B) Oral calcium supplements are best taken with meals or within 1 hour following meals.
C) It is recommended that adults 50 years of age obtain at least 1000 mg per day of elemental calcium and clients over the age of 51 obtain at least 1200 mg per day.
D) Calcium supplementation is contraindicated in clients with ventricular fibrillation.
E) Adverse effects of too much calcium include lethargy, drowsiness, weakness, headache, anorexia, nausea and vomiting, increased urination, and thirst.
Page Ref: 901
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 12.D. Analyze osteoporosis as it relates to metabolism. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with osteoporosis.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with osteoporosis.

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10) The nurse is educating a group of adults about the risks for osteoporosis. Which statements will the nurse include when discussing the use of alcohol and cigarettes? **Select all that apply.**
A) "Smoking decreases nerve supply to the bones."
B) "Nicotine increases calcium absorption, leading to decreased bone density."
C) "Moderate alcohol consumption in postmenopausal women actually may increase bone mineral content."
D) "Alcohol has a direct toxic effect on osteoclast activity, suppressing bone formation."
E) "Heavy alcohol use may be associated with nutritional deficiencies that contribute to osteoporosis."
Answer: C, E
Explanation: A) Smoking decreases the blood supply to bones.
B) Nicotine slows the production of osteoblasts and impairs the absorption of calcium, contributing to decreased bone density.
C) Moderate alcohol consumption in postmenopausal women actually may increase bone mineral content, possibly by increasing levels of estrogen and calcitonin.
D) Alcohol has a direct toxic effect on osteoblast activity, suppressing bone formation during periods of alcohol intoxication.
E) Heavy alcohol use may be associated with nutritional deficiencies that contribute to osteoporosis.
Page Ref: 898
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 12.D. Analyze osteoporosis as it relates to metabolism. Compare the risk factors and prevention of osteoporosis.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with osteoporosis.

11) Which physiological change is the primary cause of loss of height in individuals with osteoporosis?
A) Collapse of vertebral bodies
B) Decrease in length of long bones
C) Flexion of the knees and hips
D) Cervical lordosis
Answer: A
Explanation: A) The loss of height in individuals with osteoporosis occurs primarily as a result of vertebral body collapse.
B) Osteoporosis does not cause a decrease in the length of long bones.
C) The knees and hips flex to help maintain the center of gravity.
D) Osteoporosis contributes to cervical lordosis.
Page Ref: 899
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.D. Analyze osteoporosis as it relates to metabolism. Identify the clinical manifestations of osteoporosis.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with osteoporosis.

12) The nurse is caring for an 8-year-old client with cerebral palsy and limited walking ability. The parents are very protective and perform most activities for the child. Which intervention is essential in promoting bone growth and reducing the risk of osteoporosis?
A) Provide client teaching related to using restraints to prevent falls.
B) Provide client teaching related to assistive devices to encourage walking.
C) Refer the client to a dietitian to increase calcium and vitamin D intake.
D) Refer the client to an occupational therapist to increase limb movement.
Answer: B
Explanation: A) Appropriate restraints may be required to prevent falls for clients with cerebral palsy who do not have adequate body control. However, use of restraints will not increase bone growth in these clients.
B) The most effective way to prevent osteoporosis is to perform weight-bearing activities and exercise. The client has limited walking ability rather than complete paralysis, so with practice, help from parents, and the appropriate use of assistive devices, the child could learn to walk independently. This would help stimulate bone growth.
C) The nurse can inform the client and parents about the importance of calcium and vitamin D in the diet without referral to a dietitian.
D) The nurse may need to refer the client to a physical therapist, not an occupational therapist, to help teach the client to walk independently.
Page Ref: 902
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 12.D. Analyze osteoporosis as it relates to metabolism. Differentiate care of patients with osteoporosis across the lifespan.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with osteoporosis.

13) A pregnant client asks about the risk of developing osteoporosis because the fetus is using calcium from the client's body. Which response should the nurse make?
A) "You may lose small amounts of bone mass with each pregnancy, but if you only have one child, the bone loss should not be significant enough to cause osteoporosis."
B) "When bone mass is lost during pregnancy, it is very difficult to restore, and you may be at increased risk for osteoporosis later in life. You should take a calcium supplement to prevent this."
C) "If you eat a diet that is rich in calcium, any bone mass that is lost during pregnancy and breastfeeding will be restored within several months of weaning the child."
D) "The baby won't require enough calcium during development to affect your bone mass or cause osteoporosis."
Answer: C
Explanation: A) Studies indicate that the more times women are pregnant, the greater the mother's bone density.
B) If the mother does not eat a diet rich in calcium, the baby draws what it needs from the mother's bones, causing a decrease in bone mass.
C) Any bone mass that is lost during pregnancy or breastfeeding is typically easily restored several months after the infant is weaned from the breast.
D) During pregnancy, the growing fetus requires calcium to develop the skeleton. Calcium is also required for milk production.
Page Ref: 902
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.6. Describe strategies to empower patients or families in all aspects of the health care process. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Implementation

Learning Outcome: 12.D. Analyze osteoporosis as it relates to metabolism. Differentiate care of patients with osteoporosis across the lifespan.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with osteoporosis.

Exemplar 12.E Thyroid Disease

1) The nurse suspects that a client is experiencing hypothyroidism. Which question should the nurse ask during the health history?
A) "Is your skin often clammy?"
B) "Do you have brown, shiny patches on your legs?"
C) "Are you intolerant to heat?"
D) "Have you had unexplained weight gain?"
Answer: D
Explanation: A) Cool, clammy skin is found in clients with low blood sugar.
B) Brown, shiny patches on the lower extremities are associated with poor circulation.
C) Heat intolerance is associated with hyperthyroidism.
D) The client experiencing hypothyroidism often gains weight even though they are eating less.
Page Ref: 906
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.E. Analyze thyroid disease as it relates to metabolism. Identify the clinical manifestations of thyroid disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with thyroid disease.

2) The nurse is preparing an education session for nurses who work in an endocrinology clinic caring for older adult clients. Which statement about the thyroid should the nurse include in the teaching?
A) Thyroid hormone is often increased for older adult clients.
B) Symptoms of hypothyroidism in this group of clients are often confused with symptoms of aging.
C) Hypothyroidism is a congenital disease that manifests in older adult clients.
D) Hypothyroidism presents with pitting edema for this group of clients.
Answer: B
Explanation: A) Thyroid hormone is decreased in all clients with hypothyroidism.
B) The diagnosis is often missed for this group of clients as the clinical manifestations are confused with symptoms of aging.
C) Not all hypothyroidism is congenital, and it is inaccurate to state that older adult clients develop the disease due to congenital defects.
D) The older adult client will present with nonpitting edema.
Page Ref: 917
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 12.E. Analyze thyroid disease as it relates to metabolism. Differentiate care of patients with thyroid disease across the lifespan.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with thyroid disease.

3) The nurse is caring for an adult client recently diagnosed with hypothyroidism. After reviewing the nursing admission assessment, on which documented findings should the nurse plan care for this client? **Select all that apply.**

A) Hypothermia
B) Hot flashes
C) Nausea
D) Constipation
E) Tachycardia

Answer: A, D

Explanation: A) Hypothyroidism is often accompanied by hypothermia.
B) Hot flashes do not occur in hypothyroidism.
C) Nausea is not a symptom of hypothyroidism.
D) Hypothyroidism is often accompanied by constipation.
E) Tachycardia is not a symptom of hypothyroidism.

Page Ref: 913-914

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 12.E. Analyze thyroid disease as it relates to metabolism. Identify the clinical manifestations of thyroid disease.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with thyroid disease.

4) The nurse is providing care for a young adult client with exophthalmos. Which problem would be the most appropriate for this client?
A) Disturbed body image
B) Inability to cope
C) Potential for an injury
D) Inability to perform activity
Answer: A
Explanation: A) Exophthalmos is a clinical manifestation associated with hyperthyroidism and may be a problem for a young client. The nurse would plan to assess self-esteem and make appropriate referrals.
B) The client's ability to cope could be an issue, but it would probably stem from the disturbed body image.
C) Potential for an injury is not a problem related to this condition.
D) Inability to perform activities is not a problem related to this condition.
Page Ref: 911
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 12.E. Analyze thyroid disease as it relates to metabolism. Apply the nursing process in providing culturally competent care to an individual with thyroid disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with thyroid disease.

5) An older adult client with new-onset atrial fibrillation is sweating excessively. After reviewing the client's recent laboratory results, the nurse concludes that which might be causing the client's symptoms?

A) A hemoglobin (Hgb) level of 11.0 g/dL

B) A thyroid-stimulating hormone (TSH) level of 0.25 mU/mL

C) A TSH level of 18 mU/mL

D) A Hgb level of 13.8 g/dL

Answer: C

Explanation: A) Hgb 11.0 g/dL is a normal hemoglobin level.

B) TSH 0.25 mU/mL is indicative of hypothyroidism.

C) New-onset atrial fibrillation and excessive sweating are potential symptoms of hyperthyroidism. A TSH level above 5.5 mU/mL is considered high.

D) Hgb 13.8 g/dL is a normal hemoglobin level.

Page Ref: 909

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 12.E. Analyze thyroid disease as it relates to metabolism. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with thyroid disease.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with thyroid disease.

6) A client with hyperthyroidism is scheduled for surgery in a few days. Which collaborative intervention would address cardiovascular symptoms that may prevent the client from undergoing the procedure?
A) Nothing, because there is little effect on the quality of life in older adults.
B) Administration of antithyroid medications with propranolol
C) The ingestion of radioactive iodine, I-131
D) A combination treatment with levothyroxine (Synthroid) and amiodarone (Cordarone)
Answer: B
Explanation: A) There are interventions that can be taken to improve the quality of life in older clients.
B) Cardiovascular symptoms can be decreased rapidly by adding a beta-blocker, such as propranolol, to initial treatment with antithyroid medications.
C) Radioactive iodine treatment takes several weeks to take effect, and it doesn't directly address cardiovascular symptoms.
D) Levothyroxine increases thyroid hormone levels, so it would not be helpful for this client.
Page Ref: 910
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 12.E. Analyze thyroid disease as it relates to metabolism. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with thyroid disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with thyroid disease.

7) The nurse is caring for a client with Graves disease. When observing the facial features of the client the nurse notices the client's eyeballs protruding. The nurse notes that the client is exhibiting which associated sign of the disease?

A) Conjunctivitis
B) Lacrimation
C) Periorbital edema
D) Exophthalmos

Answer: D

Explanation: A) Conjunctivitis is not associated with Graves disease.
B) Lacrimation is a sign of Graves disease, but it is not associated with protruding eyeballs.
C) Periorbital edema is a sign of hypothyroidism, not hyperthyroidism.
D) Exophthalmos is a condition associated with Graves disease, caused by hyperthyroidism.

Page Ref: 907
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.E. Analyze thyroid disease as it relates to metabolism. Identify the clinical manifestations of thyroid disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with thyroid disease.

8) A client with Graves disease requests that the nurse explain the results of recent laboratory tests. Which results would the nurse anticipate discussing with the client?
A) An increase in TSH levels
B) An increase in thyroid antibodies
C) A decrease in serum T4
D) An increase in serum T3
E) A decrease in T3 uptake
Answer: D
Explanation: A) The TSH level is not increased in Graves disease.
B) Thyroid antibodies develop in Hashimoto thyroiditis.
C) In Graves disease, serum T4 level increases.
D) In Graves disease, serum T3 increases.
E) In Graves disease, T3 uptake test is increased.
Page Ref: 909
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 12.E. Analyze thyroid disease as it relates to metabolism. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with thyroid disease.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with thyroid disease.

9) Which physiological change causes edema in adults with hypothyroidism?
A) Excess reabsorption of water and sodium in the kidneys
B) Decreased plasma oncotic pressure in the capillaries
C) Water retention in mucoprotein deposits in the interstitial spaces
D) Increased capillary permeability in the extremities
Answer: C
Explanation: A) The redistribution of water may trigger increased reabsorption of water and sodium in the kidneys, but excess reabsorption is not the cause of the edema.
B) Decreased plasma oncotic pressure is a less common cause of edema and may be due to other etiologies.
C) The hypothyroid state in adults is sometimes called myxedema, which reflects the accumulation of nonpitting edema in connective tissues throughout the body. The edema is the result of water retention in mucoprotein deposits in the interstitial spaces.
D) Increased capillary permeability is a less common cause of edema and may be due to other etiologies.
Page Ref: 914
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.E. Analyze thyroid disease as it relates to metabolism. Describe the pathophysiology of thyroid disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with thyroid disease.

10) Increasing circulating levels of thyroid hormone heighten the sympathetic nervous system's physiologic response to stimulation. Which effect does this have on the cardiac system?
A) Increases stroke volume
B) Decreases cardiac rate
C) Lengthens the QRS interval
D) Decreases blood pressure
Answer: A
Explanation: A) The sensitizing effect of abnormally elevated thyroid hormone levels increases the cardiac rate and stroke volume. As a result, cardiac output and peripheral blood flow increase.
B) The sensitizing effect of abnormally elevated thyroid hormone levels increases cardiac rate.
C) Increased cardiac rate would result in a shortened QRS interval.
D) Stimulation of the sympathetic nervous system increases blood pressure.
Page Ref: 906
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 12.E. Analyze thyroid disease as it relates to metabolism. Describe the pathophysiology of thyroid disease.
MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with thyroid disease.

11) Which client is at the greatest risk for developing hypothyroidism?

A) A 21-year-old woman who has a mother with Graves disease

B) A 32-year-old man who has an uncle with type 1 diabetes mellitus

C) A 57-year-old woman whose aunt had systemic lupus erythematosus

D) A 72-year-old man whose father had cardiovascular disease

Answer: C

Explanation: A) Risk factors for hypothyroidism include being female between the ages of 30 and 60.

B) Men are at a lower risk for hypothyroidism.

C) Risk factors for hypothyroidism include being female between the ages of 30 and 60 and having a close relative with an autoimmune condition.

D) Men are at a lower risk for hypothyroidism.

Page Ref: 913

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 12.E. Analyze thyroid disease as it relates to metabolism. Compare the risk factors and prevention of thyroid disease.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with thyroid disease.

12) The nurse is caring for a newborn born to a mother with uncontrolled hyperthyroidism during pregnancy. For which complication should the nurse monitor the newborn?

A) Late closure of fontanels
B) Slow heart rate
C) Rapid weight gain
D) Breathing problems

Answer: D

Explanation: A) Hyperthyroidism in a newborn can result in early closure of fontanels.
B) Hyperthyroidism in a newborn can result in a rapid heart rate.
C) Hyperthyroidism in a newborn can result in poor weight gain.
D) Hyperthyroidism in a newborn can result in breathing issues due to an enlarged thyroid gland that presses against the trachea.

Page Ref: 911

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 12.E. Analyze thyroid disease as it relates to metabolism. Differentiate care of patients with thyroid disease across the lifespan.

MNL LO: Demonstrate understanding of the concept of metabolism in the care of a patient with thyroid disease.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e **(Pearson)**
Module 13 Mobility

The Concept of Mobility

1) An adult client is diagnosed with a degenerative bone disease that is impairing mobility. Based on this information alone, which action should the nurse complete first?
A) Implement a low-level exercise program for the client
B) Assess the client's pain management
C) Teach the client relaxation techniques
D) Refer the client to a dietitian
Answer: B
Explanation: A) When caring for a client with a degenerative bone disease that is impairing mobility, the nurse should assess pain management prior to implementing an exercise program.
B) When caring for a client with a degenerative bone disease that is impairing mobility, the nurse should assess pain management first.
C) When caring for a client with a degenerative bone disease that is impairing mobility, the nurse should assess pain management prior to teaching relaxation exercises.
D) When caring for a client with a degenerative bone disease that is impairing mobility, the nurse should assess pain management prior to referring to a dietitian.
Page Ref: 933
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.6. Analyze independent interventions nurses can implement for patients with alterations in mobility.
MNL LO: Analyze the concept of mobility and its application to nursing care.

2) A preadolescent client who fell from a balance beam in physical education class injures an ankle. Which action should the nurse take?
A) Refer the client to physical therapy
B) Place an ice pack on the client's ankle
C) Plan for a corticosteroid injection
D) Order an x-ray of the ankle
Answer: B
Explanation: A) If physical therapy is needed, the referral would be given after the ankle has had time to heal.
B) An appropriate intervention for a client who experiences an ankle injury is placing ice on the ankle to limit swelling.
C) A corticosteroid injection would be more appropriate for a client with osteoarthritis, not an acute ankle injury.
D) Ordering an x-ray of the ankle is outside the nurse's scope of practice.
Page Ref: 929
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 13.6. Analyze independent interventions nurses can implement for patients with alterations in mobility.
MNL LO: Analyze the concept of mobility and its application to nursing care.

3) The nurse is conducting a gait and posture assessment for a client who is experiencing mobility issues. Which action by the nurse is appropriate during this assessment?
A) Assessing the client's muscle mass and strength
B) Measuring the length and circumference of the client's extremities
C) Inspecting the client's spine for curvature
D) Palpating the client for tenderness and pain
Answer: C
Explanation: A) Assessing muscle mass and strength is a part of the physical assessment for clients who are experiencing mobility issues.
B) Measuring the length and circumference of the extremities is completed for clients who are experiencing mobility issues.
C) When assessing a client's gait and posture, the nurse should be sure to inspect the client's spine for curvature.
D) Palpating for tenderness and pain are part of the physical assessment for clients who are experiencing mobility issues.
Page Ref: 935
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.5. Differentiate among common assessment procedures and tests used to examine mobility.

MNL LO: Analyze the concept of mobility and its application to nursing care.

4) The nurse is caring for a client who is experiencing limited mobility related to a musculoskeletal alteration. Which laboratory tests would be useful to diagnose the client? **Select all that apply.**
A) Magnetic resonance imaging (MRI)
B) Alkaline phosphatase (ALP)
C) Human leukocyte antigen-B27 (HLA-B27)
D) Rheumatoid factor (RF)
E) Electromyography (EMG)
Answer: B, C, D
Explanation: A) MRI is a diagnostic test used to diagnose the cause of alterations in mobility.
B) ALP is produced by bone and other organs. Increased ALP may indicate bone disease, bone fracture, bone tumors, osteomalacia, Paget disease, or rickets. Decreased ALP may indicate Wilson disease.
C) The presence of HLA-B27 indicates an increased risk for ankylosing spondylitis and arthritis.
D) Elevated levels of RF may indicate rheumatoid arthritis, scleroderma, lupus erythematosus, and adult Still disease.
E) EMG is a diagnostic test used to diagnose the cause of alterations in mobility.
Page Ref: 941
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 13.5. Differentiate among common assessment procedures and tests used to examine mobility.
MNL LO: Analyze the concept of mobility and its application to nursing care.

5) A client who is 28 weeks pregnant asks what can be done for lower back pain. Which response should the nurse make?

A) "Back pain is common during pregnancy and can usually be managed by taking nonsteroidal anti-inflammatory drugs (NSAIDs)."

B) "Let's talk about some postural adjustments that might help alleviate your pain."

C) "Back pain during pregnancy is often related to kidney infection. Have you experienced any recent urinary problems, including pain when voiding?"

D) "The physician will likely order an x-ray to investigate potential causes of your pain."

Answer: B

Explanation: A) The recommended pain medication is acetaminophen, because NSAIDs are contraindicated during pregnancy.

B) Back pain is common during pregnancy due to strain on the back from the growing uterus and fetus; abdominal weakness from stretched abdominal muscles; and hormonal changes that loosen the ligaments in the joints of the pelvis. Pregnancy-related back pain is usually managed conservatively. Postural changes or other adaptations can help increase mobility and decrease discomfort.

C) Kidney infection is not a leading cause of back pain in pregnant women.

D) Although diagnostic imaging may be useful, x-rays should be avoided because they deliver ionizing radiation to the fetus.

Page Ref: 946

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

WwW.TeSt.Ws

Learning Outcome: 13.8. Differentiate considerations related to the care of patients with alterations in mobility throughout the lifespan.

MNL LO: Analyze the concept of mobility and its application to nursing care.

6) The nurse is caring for a preadolescent male client who is accompanied by a parent. Which statement by the parent would be consistent with the client experiencing growing pains?
A) "My child often complains about sore arms and legs.”
B) "My child seems to get injured very easily, especially broken bones."
C) "My child often doesn't want to walk because of knee pain."
D) "My child occasionally complains of lower back pain."
Answer: A
Explanation: A) Long bones of children contain an epiphyseal plate that serves as a location for bone growth. Rapid bone growth in these long bones may produce growing pains as the lengthening bones pull on the muscles. Because this only occurs in the long bones, growing pains are most likely to be felt in the arms and legs.
B) Growing pains are not associated specifically with fractured bones.
C) Growing pains would not cause joint pain.
D) Growing pains would not cause lower back pain.
Page Ref: 945
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 13.8. Differentiate considerations related to the care of patients with alterations in mobility throughout the lifespan.
MNL LO: Analyze the concept of mobility and its application to nursing care.

7) The nurse is planning care for a client who is experiencing an alteration in mobility. Which would the nurse include as an independent nursing intervention?
A) Instructing on the importance of proper nutrition and an active lifestyle
B) Administering a prescribed nonsteroidal anti-inflammatory drug (NSAID)
C) Identifying necessary modifications to the home environment
D) Prescribing a skeletal muscle relaxant
Answer: A
Explanation: A) An appropriate independent nursing intervention for a client who is experiencing an alteration in mobility is providing instruction on the importance of proper nutrition and an active lifestyle.
B) Administering a prescribed NSAID is an example of a collaborative intervention that the nurse can implement.
C) Identifying necessary modifications for the home environment is a collaborative intervention often implemented by the occupational therapist.
D) Although it is appropriate for the nurse to administer a skeletal muscle relaxant, it is outside the scope of nursing practice to prescribe this medication.
Page Ref: 942
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

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Learning Outcome: 13.6. Analyze independent interventions nurses can implement for patients with alterations in mobility.
MNL LO: Analyze the concept of mobility and its application to nursing care.

8) The nurse is providing care for a client who is experiencing subjective symptoms of carpal tunnel syndrome. Which test should the nurse anticipate being performed by a provider during the physical assessment of this client?
A) Bulge test
B) Ballottement test
C) Phalen test
D) McMurray test
Answer: C
Explanation: A) The Bulge test is used to assess the knee.
B) The ballottement test is used to assess the knee.
C) Phalen test is a special assessment to determine whether the client is experiencing carpal tunnel syndrome. With this test, the wrists are held in acute flexion for 60 seconds. Numbness, tingling, or pain may indicate carpal tunnel syndrome.
D) The McMurray test is used to assess the knee.
Page Ref: 939
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.5. Differentiate among common assessment procedures and tests used to examine mobility.
MNL LO: Analyze the concept of mobility and its application to nursing care.

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9) The nurse is caring for an adult client who sustained a right distal radial fracture and a left tibia fracture. Which mobility aid does the nurse anticipate being used for this client?
A) Lofstrand crutches
B) Platform crutches
C) Walker
D) Axillary crutches
Answer: B
Explanation: A) Lofstrand crutches require use of the wrists.
B) This client has fractures in both the leg and wrist. Platform crutches are used for clients who are unable to bear weight on their wrists.
C) A walker requires the use of the wrists.
D) Axillary crutches require the use of the wrists.
Page Ref: 944
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 13.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in mobility.
MNL LO: Analyze the concept of mobility and its application to nursing care.

10) Which cells should the nurse identify that produce the matrix for bone formation?
A) Osteoclasts
B) Sarcomeres
C) Osteoblasts
D) Epiphyseal plates
Answer: C
Explanation: A) Osteoclasts are cells that break down bone tissue.
B) Sarcomeres are filaments made of actin or myosin that are found within muscle.
C) Osteoblasts are the cells that produce the matrix for bone formation.
D) Epiphyseal plates are areas of cartilage located between the epiphysis and diaphysis of a child's long bones.
Page Ref: 945
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.1. Analyze the physiology of mobility in the body.
MNL LO: Analyze the concept of mobility and its application to nursing care.

11) Which score would a nurse select from the muscle function grading scale if the client has full strength and range of motion in a given joint?

A) 0
B) 5
C) 8
D) 10
Answer: B
Explanation: A) A score of 0 indicates paralysis, meaning that the client cannot contract the muscles associated with a given joint.
B) A score of 5 indicates that the client can move a joint through the full range of motion under full resistance.
C) The muscle function grading scale ranges from 0 to 5.
D) The muscle function grading scale ranges from 0 to 5.
Page Ref: 934
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.5. Differentiate among common assessment procedures and tests used to examine mobility.
MNL LO: Analyze the concept of mobility and its application to nursing care.

12) Within the human body, which type of connective tissue connects bones to other bones to form a joint?
A) Tendon
B) Ligament
C) Cartilage
D) Myelin
Answer: B
Explanation: A) Tendons connect bones to muscles and carry the contractile forces from the muscle to the bone to cause movement.
B) Ligaments connect bones to other bones to form a joint.
C) Cartilage is a type of flexible connective tissue found in many locations throughout the body.
D) Myelin is not a type of connective tissue but rather a fatty substance that insulates neuronal axons and promotes faster signal transmission.
Page Ref: 926
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.1. Analyze the physiology of mobility in the body.
MNL LO: Analyze the concept of mobility and its application to nursing care.

13) A client presents with an alteration in mobility. Which finding would suggest damage to the muscle?
A) Increased PTH levels
B) Decreased PTH levels
C) Decreased CK levels
D) Increased CK levels
Answer: D
Explanation: A) Parathyroid hormone (PTH) levels are not linked to muscle inflammation but rather to osteoporosis, kidney disease, parathyroid gland tumors, lack of calcium, and vitamin D disorders.
B) Parathyroid hormone (PTH) levels are not linked to muscle inflammation but rather to osteoporosis, kidney disease, parathyroid gland tumors, lack of calcium, and vitamin D disorders.
C) Creatine kinase (CK) is used to detect muscle damage, muscle inflammation, rhabdomyolysis, polymyositis, and muscular dystrophy. Increased CK levels are suggestive of increased muscle inflammation.
D) Creatine kinase (CK) is used to detect muscle damage, muscle inflammation, rhabdomyolysis, polymyositis, and muscular dystrophy. Increased CK levels are suggestive of increased muscle inflammation.
Page Ref: 941
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 13.5. Differentiate among common assessment procedures and tests used to examine mobility.
MNL LO: Analyze the concept of mobility and its application to nursing care.

Exemplar 13.A Back Problems

1) The nurse is providing care to a client who is experiencing back pain. Which item in the client's history is a known risk factor for disc herniation?
A) 49 years of age
B) Female gender
C) Short stature
D) Anorexia
Answer: A
Explanation: A) The client's age is a known risk factor; herniated discs are most common between the ages of 30 and 50, because discs naturally degenerate with age.
B) Male gender is a risk factor for back pain.
C) Other risk factors include tall height.
D) Other risk factors include excess weight (which is extremely uncommon in clients with anorexia).
Page Ref: 949
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.A. Analyze back problems as they relate to mobility. Compare the risk factors for and prevention of back problems.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with back problems.

2) Which client is at increased risk for back problems? **Select all that apply.**

A) A 45-year-old man who has played golf three times a week for the past 20 years

B) An 18-year-old woman who has been a distance runner since middle school

C) A 62-year-old man who is a heavy truck mechanic and has a body mass index (BMI) of 30

D) A 12-year-old boy who has a history of cerebral palsy and a current BMI of 21

E) A 78-year-old man with a 40 pack-year smoking history who was recently widowed

Answer: C, D, E

Explanation: A) Playing golf does not cause a high risk of back problems.

B) Running track does not increase the risk of back problems.

C) Factors that increase the risk of herniated intervertebral discs include male gender, age (clients over 30 are at higher risk), obesity, history of smoking, and regularly engaging in heavy lifting. The 62-year-old client has multiple traits that puts him at elevated risk of disc herniation.

D) Risk factors for scoliosis include age of between 9 and 15 and history of cerebral palsy; thus, the 12-year-old client is at elevated risk for this condition.

E) Factors that increase the risk of herniated intervertebral discs include male gender, age (clients over 30 are at higher risk), obesity, history of smoking, and regularly engaging in heavy lifting. The 78-year-old client has multiple traits that puts him at elevated risk of disc herniation.

Page Ref: 949

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 13.A. Analyze back problems as they relate to mobility. Compare the risk factors for and prevention of back problems.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with back problems.

3) A preadolescent client is recovering from spinal fusion surgery for scoliosis. Which nursing interventions should the nurse implement to address comfort and mobility? **Select all that apply.**
A) Reposition every 2 hours.
B) Monitor intake and output.
C) Encourage and assist with range of motion (ROM) exercises every 4 hours while awake.
D) Administer pain medication around the clock.
E) Encourage incentive spirometer use every 4 hours while awake.
Answer: A, C, D
Explanation: A) Interventions that address movement restrictions and/or pain in a preadolescent client recovering from spinal fusion include repositioning every 2 hours.
B) Monitoring intake and output would be applicable for the problem of fluid imbalance.
C) Interventions that address movement restrictions and/or pain in a preadolescent client recovering from spinal fusion include encouraging and assisting with ROM exercises every 4 hours while awake.
D) Interventions that address movement restrictions and/or pain in a preadolescent client recovering from spinal fusion include administering pain medication around the clock.
E) The use of an incentive spirometer may be appropriate after surgery, but it would relate to a problem with oxygenation.
Page Ref: 953
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 13.A. Analyze back problems as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with back problems.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with back problems.

4) A client recovering from surgery for a herniated disc has a HR 100, RR 22, BP 130/86 mmHg, T 98.8°F, and pain rating of 7 on a scale of 0 to 10. Which problem is the highest priority for this client?
A) Compromised physical mobility
B) Acute pain
C) Risk for injury
D) Chronic pain
Answer: B
Explanation: A) Compromised physical mobility would be the result of the surgery.
B) The client is currently experiencing acute pain as evidenced by elevated vital signs and a pain rating of 7 on a 0-to-10 scale.
C) There is no evidence that the client is at risk for injury.
D) The client was likely experiencing chronic pain prior to the surgery, and it probably contributed to the need for the procedure.
Page Ref: 952
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 13.A. Analyze back problems as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with back problems.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with back problems.

5) The nurse is planning care for a client with acute back pain who is a single mother of two small children and works part-time as a receptionist. Based on this information, which nursing intervention is the highest priority?
A) Instructing the client in appropriate body mechanics for lifting and ways to modify her work environment
B) Suggesting that the client take time off from work until her back is healed
C) Obtaining an order for nonsteroidal anti-inflammatory drugs (NSAIDs) from the client's healthcare provider
D) Suggesting that the client's children be taken care of by an extended family member until the client's back is healed
Answer: A
Explanation: A) The client is at risk for injury given that she has two small children who need care and a part-time job that is sedentary. To help the client better manage health, the nurse should provide instruction on appropriate body mechanics for lifting and ways to modify the work environment.
B) Suggesting that the client take time off from work may or may not be appropriate and should not be included in the plan of care.
C) The client may or may not be prescribed NSAIDs.
D) Having extended family members care for the children may or may not be appropriate and should not be included in the plan of care.
Page Ref: 949-950, 953
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 13.A. Analyze back problems as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with back problems.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with back problems.

6) The nurse is planning care for a client who is 1 day postoperative after spinal fusion surgery. Which outcome should the nurse identify for this client?
A) The client will remain in prone position.
B) The client will maintain urine output at 20 mL per hour.
C) The client will use the incentive spirometer every 2 hours.
D) The client will void 12 hours after surgery.
Answer: C
Explanation: A) The client is not expected to remain in a prone position.
B) Urine output should be at least 30 mL per hour.
C) An appropriate outcome for this client is the use of an incentive spirometer every 2 hours.
D) The client should void within 8 hours of surgery.
Page Ref: 954
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 13.A. Analyze back problems as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with back problems.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with back problems.

7) The nurse is documenting the interprofessional team report on an adolescent client who has a 35-degree Cobb angle confirmed by x-ray. Which interventions should the nurse anticipate being included in the collaborative plan of care for this client? **Select all that apply.**
A) Obtaining a physical therapy consult prior to surgical intervention
B) Maintaining the existing curvature with no increase
C) Bracing for 12-23 hours per day and providing a support group referral
D) Administering nonopioid analgesics and a TLSO or Milwaukee brace
E) Instructing the client on exercises and appropriate support groups
Answer: C, D, E
Explanation: A) Severe scoliosis requires surgical intervention and subsequent physical therapy.
B) Mild scoliosis requires observation every 3-6 months.
C) Treatment of children with a Cobb angle between 25 and 45 degrees consists of bracing for 12-23 hours per day and a support group referral.
D) Treatment of children with a Cobb angle between 25 and 45 degrees consists of bracing with a TLSO or Milwaukee brace and mild pain medication.
E) Treatment of children with a Cobb angle between 25 and 45 degrees consists of counseling or support group referral, and exercise to improve posture and maintain or increase spine flexibility.
Page Ref: 955
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 13.A. Analyze back problems as they relate to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with back problems.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with back problems.

8) Which region of the spine is the most common location of herniated discs?
A) C1-C2
B) T7-T8
C) L4-L5
D) S1-S2
Answer: C
Explanation: A) The most common location of herniated discs is not between cervical 1 and 2.
B) The most common location of herniated discs is not between thoracic 7 and 8.
C) The most common location of herniated discs is the lumbar region (L4-L5).
D) The most common location of herniated discs is not sacral 1 and 2.
Page Ref: 949
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.A. Analyze back problems as they relate to mobility. Identify the clinical manifestations of back problems.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with back problems.

9) On the first postoperative day after spinal fusion, the nurse assesses a client and notes the following vital signs: T 39.2°C, BP 100/50 mmHg, HR 118, and RR 23. Drainage at the client's incision site is clear and tests positive for glucose. Which assessment parameter indicates the highest risk for surgical wound infection?
A) Temperature
B) Incisional drainage positive for glucose
C) Heart rate 118 bpm
D) Presence of incisional drainage
Answer: B
Explanation: A) Temperature above 38°C is a fever. Fever may be a sign of infection anywhere in the body, not just at the surgical wound site.
B) The presence of glucose in the drainage is indicative of cerebrospinal fluid (CSF). A CSF leak increases the risk of infection of the surgical site and meninges.
C) The client's heart rate could be elevated for numerous reasons.
D) Incisional drainage isn't necessarily problematic.
Page Ref: 954
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.A. Analyze back problems as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with back problems.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with back problems.

10) The mother of a preadolescent client meets with the school nurse to discuss the client's recent diagnosis of scoliosis. Which interventions would be appropriate for the problem of disturbed body image related to deformity and brace? **Select all that apply.**
A) Including the student and family in a meeting to elicit her feelings about scoliosis and wearing a brace
B) Offering to arrange a meeting for the student with an 8th grader who has scoliosis
C) Encouraging the student and family to register for home schooling to minimize the risk of ridicule
D) Teaching the student and family about clothing that will hide the brace
E) Suggesting that the pediatrician prescribe an anti-anxiety agent for the student
Answer: A, B, D
Explanation: A) Interventions for the problem of a disturbed body image include asking the student to explain feelings about scoliosis and wearing a brace.
B) For disturbed body image, offering a support group or person with the condition is appropriate.
C) Avoiding other children and community encounters will increase the client's risk of social isolation.
D) Teaching the student and family about clothes that will hide the brace is appropriate.
E) There is not enough information to indicate a problem that requires pharmacologic management.
Page Ref: 958
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 13.A. Analyze back problems as they relate to mobility. Differentiate considerations for care of patients with back problems across the lifespan.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with back problems.

11) During a home care visit, an older adult client begins to cry softly when asked about coping with back pain. The client states, "My back hurts bad all the time. I am so confused about all these tests and scared that the doctor wants me to have surgery." Which action should the nurse take?

A) Asking the client to rate the pain on a scale of 0 to 10
B) Explaining potential procedures in a way the client will understand
C) Administering all pain medication as ordered
D) Attentively listening to the client's thoughts and fears

Answer: D

Explanation: A) A pain assessment has most likely already been completed.
B) Explaining potential procedures will be done after the assessment is complete and the plan of care is set in place.
C) The client is at home and is most likely self-administering medications.
D) The priority nursing intervention for a client who is ready to disclose emotions is to attentively listen to the client's thoughts and fears.

Page Ref: 954

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 13.A. Analyze back problems as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with back problems.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with back problems.

12) An adolescent client with scoliosis has a Cobb angle of 32 degrees. For which treatment should the nurse anticipate preparing for this client?
A) No specific treatment.
B) Physical therapy.
C) Wearing a brace.
D) Spinal fusion surgery.
Answer: C
Explanation: A) Typically, clients with Cobb angles less than 15 degrees do not require treatment.
B) Clients with Cobb angles of 15 to 25 degrees are treated conservatively with physical therapy.
C) Clients with Cobb angles between 25 and 40 degrees are advised to wear a corrective brace.
D) For clients with Cobb angles in excess of 40 degrees, spinal fusion surgery is the most effective option.
Page Ref: 955
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 13.A. Analyze back problems as they relate to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with back problems.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with back problems.

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13) Which condition or symptom is most common in clients with a herniated cervical disc?
A) Sciatica
B) Stiff neck and shoulder pain
C) Changes in knee and ankle reflexes
D) Cauda equina syndrome
Answer: B
Explanation: A) Sciatica is associated with lumbar disc herniation.
B) Herniation of the cervical discs is more commonly associated with numbness, tingling, muscle spasms, and weakness in the upper body, as well as stiff neck and shoulder pain that radiates to the arms and fingers.
C) Changes in knee and ankle reflexes is associated with lumbar disc herniation.
D) Cauda equina syndrome is associated with lumbar disc herniation.
Page Ref: 951
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.A. Analyze back problems as they relate to mobility. Identify the clinical manifestations of back problems.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with back problems.

Exemplar 13.B Fractures

1) A client sustained multiple fractures in a motor vehicle crash. Of the various fracture types sustained by the client, which type places the client at highest risk for osteomyelitis?
A) Avulsion
B) Open
C) Comminuted
D) Depression
Answer: B
Explanation: A) An avulsion fracture is closed from the environment and presents a lower risk of infection.
B) The risk for osteomyelitis, or bone infection, is highest with an open fracture, in which the bone breaks through the skin.
C) A comminuted fracture is closed from the environment and presents a lower risk of infection.
D) A depression fracture is closed from the environment and presents a lower risk of infection.
Page Ref: 961
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.B. Analyze fractures as they relate to mobility. Describe the pathophysiology of fractures.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with fractures.

2) The nurse is caring for clients in an assisted living facility. Which resident would the nurse identify as being at the highest risk for the development of fractures from a fall?
A) A resident who participates in resistance training exercises three times a week and takes a calcium supplement
B) A resident who hikes in the woods once a week and smokes 14 cigarettes per day
C) A resident who line dances twice per week and has a glass of wine with dinner
D) A resident who teaches yoga four times per week and is lactose intolerant
Answer: B
Explanation: A) Resistance training and taking a calcium supplement decreases the risk of fracture with a fall.
B) Among older adult clients, smoking is the highest-risk behavior. Although exercise helps prevent fractures, hiking on an uneven surface can be a risk.
C) Line dancing decreases the risk of fracture with a fall. Consuming one glass of wine each day is not a risk factor for fractures from a fall.
D) Yoga decreases the risk of fracture with a fall. Lactose intolerance can lower calcium intake, although there are other sources of dietary or supplemental calcium that lactose-intolerant clients can use to reduce their fracture risk.
Page Ref: 962-963
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.B. Analyze fractures as they relate to mobility. Compare the risk factors for and prevention of fractures.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with fractures.

3) The nurse is teaching an older adult client and caregiver about appropriate ways to decrease the client's risk for falls. Which interventions are appropriate for the nurse to include in this teaching session? **Select all that apply.**
A) Start walking for exercise several times per week.
B) Wear sensible shoes with good support when shopping.
C) Wear socks when walking in the kitchen.
D) Encourage the use of throw rugs throughout the home.
E) Make sure hallways and stairways have adequate lighting, even at night.
Answer: A, B, E
Explanation: A) A mild to moderate exercise program is beneficial, as it helps improve balance and strength, thus reducing the likelihood of falls.
B) Interventions that are appropriate to decrease this client's risk for falls include wearing sensible shoes with good support when shopping.
C) Nonslip footwear should be encouraged.
D) Throw rugs should be discouraged.
E) Interventions that are appropriate to decrease this client's risk for falls include making sure hallways and stairways have adequate lighting, even at night.
Page Ref: 962
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 13.B. Analyze fractures as they relate to mobility. Compare the risk factors for and prevention of fractures.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with fractures.

4) The nurse is teaching a parent warning signs and symptoms to watch for in a child who will be discharged with a full leg cast. Which statements by the parent indicate the need for further instruction? **Select all that apply.**
A) "If the foot turns white and cold, I should call the physical therapist."
B) "I can expect that my child will have some pain, but the medicine should help."
C) "We can use a blow dryer on warm to help with the itching that my child will experience."
D) "We can cut a hole in the cast if my child's foot swells until we get to the doctor's office."
E) "It is okay if the plaster cast gets damp as long as I blow dry it."
Answer: A, C, D, E
Explanation: A) If the child's foot turns white and cold, the family should contact the physician.
B) The option that indicates appropriate understanding of cast care is the mother's statement that her child may have pain that will be relieved by medication.
C) Itching may be helped by use of a blow dryer on the cool setting.
D) Holes should not be cut in the cast.
E) The plaster should stay dry at all times.
Page Ref: 966
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 13.B. Analyze fractures as they relate to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a fracture.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with fractures.

5) A client in an inpatient rehabilitation unit is currently in halo traction. Based on this information, which problem should be the priority for the client?
A) Potential for peripheral neurovascular dysfunction
B) Risk for infection
C) Potential for disuse syndrome
D) Acute pain
Answer: B
Explanation: A) Halo traction is not connected to weights, so the problem for peripheral neurovascular dysfunction is not applicable.
B) Halo traction uses pins that are surgically implanted in the skull, which increases the risk for infection.
C) Risk for disuse syndrome is another appropriate but lower-priority problem.
D) Acute pain is not as high a priority as the risk for infection.
Page Ref: 968
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 13.B. Analyze fractures as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with a fracture.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with fractures.

6) The x-ray of a client 14 weeks post-ulnar fracture exhibits no callus formation. Based on this data, which collaborative intervention should the nurse anticipate?
A) The physical therapist will set up Buck traction.
B) The surgeon will schedule a consultation with the client.
C) The pharmacist will educate the client on antibiotics.
D) The nurse will counsel the client on starting range-of-motion exercise.
Answer: B
Explanation: A) Buck traction is not indicated for nonunion of a fracture.
B) An ulnar fracture that does not show callus formation after 14 weeks would be classified as experiencing nonunion. Nonunions frequently require surgical correction.
C) Antibiotics are not indicated for nonunion of a fracture.
D) Exercise is not indicated for nonunion of a fracture.
Page Ref: 960
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 13.B. Analyze fractures as they relate to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a fracture.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with fractures.

7) The nurse is caring for a client with a fracture requiring a plaster cast. Which nursing intervention is appropriate for this client?
A) Prescribing opioid pain medication
B) Assessing the client's neurovascular status
C) Discouraging client ambulation
D) Encouraging the client to keep the cast damp
Answer: B
Explanation: A) The nurse can administer an opioid pain medication but cannot prescribe one.
B) It is appropriate for the nurse to assess the client's neurovascular status to monitor for compartment syndrome related to the fracture.
C) The nurse should encourage the client to ambulate.
D) The nurse should encourage the client to keep the plaster cast dry.
Page Ref: 966
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 13.B. Analyze fractures as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with a fracture.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with fractures.

8) The nurse in an orthopedic outpatient clinic expects to see several clients with fractures for follow-up. Which client is at highest risk for a delayed union?
A) A 20-year-old college student with type I diabetes mellitus who sustained a fractured tibia in a bicycle accident. The nutrition recall tool completed during the client's last visit was consistent with American Diabetic Association (ADA) guidelines.
B) A 62-year-old bartender with a history of peptic ulcer disease who sustained a fractured clavicle breaking up a fight at work. During his prior visit, the client stated he was upset that his injury required him to abstain from upper body resistance training.
C) A 49-year-old teacher with osteoporosis who sustained an open ulnar fracture in a motor vehicle crash. At her last visit, the client reported that she had cut down smoking to 10 cigarettes per day.
D) A 55-year-old accountant who sustained fractures to the 4th and 5th right metatarsals. The client has a history of hypertension that is well controlled with medication.
Answer: C
Explanation: A) Although diabetes does increase the risk of delayed union, this client is young and exercised on a bicycle prior to the crash. If the client is following an ADA diet, there is adequate intake of vitamin D and calcium, which fosters bone healing.
B) Peptic ulcer disease is not a risk factor for delayed bone healing.
C) Evaluating the risk of delayed union requires knowledge of the factors that impact bone healing. The client at greatest risk of delayed union has two factors that decrease the likelihood of proper healing: an open fracture and osteoporosis. This client also uses tobacco, which decreases blood supply to the healing bone.
D) Hypertension is not a risk factor for delayed bone healing.
Page Ref: 960, 963

Cognitive Level: Evaluating
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.B. Analyze fractures as they relate to mobility. Compare the risk factors for and prevention of fractures.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with fractures.

9) A client with an open reduction and internal fixation of a fractured femur reports right calf pain. The nurse notes that the client's right calf is 3.5 cm larger than the left calf with generalized posterior erythema. The right calf is tender to touch, and the dorsalis pedis pulse is 3/4+ bilaterally. Which action should the nurse make a priority?
A) Use a Doppler stethoscope to confirm pedal pulses.
B) Notify the healthcare provider of the findings.
C) Prepare to apply a cast to the right leg.
D) Prepare to administer intravenous heparin.
Answer: B
Explanation: A) If a pedal pulse can be palpated, then a Doppler stethoscope is not needed.
B) These findings indicate possible deep vein thrombosis (DVT). The nurse's first action upon assessing these signs and symptoms should be to notify the healthcare provider immediately.
C) A cast is not indicated with internal fixation.
D) Intravenous heparin will likely be ordered after the condition is confirmed by the provider.
Page Ref: 964
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 13.B. Analyze fractures as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with a fracture.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with fractures.

10) A client who is hospitalized after a left hip fracture is scheduled for surgery late this afternoon. After receiving report, the nurse evaluates the Buck traction applied by a new physical therapist. Which finding would indicate that the traction is correctly applied?
A) A foam boot covers the right lower leg from the knee down.
B) Twenty-pound weights are connected to the bottom of a foam boot.
C) Weights are supported by a stool at the end of the bed.
D) The left knee and hip are in alignment above a foam boot.
Answer: D
Explanation: A) A foam boot covers the affected leg–in this case, the left leg, not the right.
B) Because Buck traction is a type of skin traction, it does not involve heavy weights; usually, 5-pound weights are used.
C) The weights always hang free from a pulley and are never supported by a stool at the end of the bed.
D) The correct placement of Buck traction permits the client's left knee and hip to align.
Page Ref: 967
Cognitive Level: Evaluating
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 13.B. Analyze fractures as they relate to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a fracture.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with fractures.

11) During which phase of the fracture healing process is woven bone replaced by lamellar bone?
A) Reactive
B) Reparative
C) Remodeling
D) Inflammatory
Answer: C
Explanation: A) In the reactive or inflammatory phase of fracture healing, a hematoma forms around the injury. Inflammatory cells then enter the wound and degrade debris and bacteria in the area.
B) In the reparative phase, fibroblasts, osteoblasts, and chondroblasts begin to secrete collagen to form fibrocartilage, which develops into a soft callus that joins the fractured bone. Once the soft callus is formed, it is replaced by woven bone through endochondral ossification, which forms a hard callus.
C) During the remodeling phase, woven bone is replaced by highly organized lamellar bone.
D) In the reactive or inflammatory phase of fracture healing, a hematoma forms around the injury. Inflammatory cells then enter the wound and degrade debris and bacteria in the area.
Page Ref: 960
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 13.B. Analyze fractures as they relate to mobility. Describe the etiology of fractures.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with fractures.

12) Which fracture presents the greatest risk for development of fat embolism syndrome?
A) Open fracture of the fibula
B) Closed fracture of the femur
C) Open fracture of the humerus
D) Closed fracture of the clavicle
Answer: B
Explanation: A) Fat embolism does not usually occur with a fractured fibula.
B) Fat embolism syndrome may occur in conjunction with closed fractures of the long bones or pelvis. The fracture of the femur is the injury that presents the greatest risk for development of fat embolism syndrome.
C) Fat embolism does not usually occur with a fractured humerus.
D) Fat embolism does not usually occur with a fractured clavicle.
Page Ref: 964
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.B. Analyze fractures as they relate to mobility. Identify the clinical manifestations of fractures.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with fractures.

Exemplar 13.C Hip Fractures

1) The nurse is presenting a program at a senior center on how to survive a fall. Which statement by a program participant indicates that this person needs clarification about what emergency actions to take after a fall?
A) "I should crawl to a phone on the affected side to keep it stable against a hard surface."
B) "I should try to cover myself with a blanket while I wait for help to arrive."
C) "To call for help, I can scoot on my bottom to a low wall-mounted phone."
D) "If possible, I can crawl to a stairway and use the stairs to lift up to a standing position."
Answer: A
Explanation: A) These clients should be instructed to turn onto the stomach and crawl to the phone.
B) While waiting for help to arrive, clients should cover themselves with a blanket if possible, to help prevent shock.
C) These clients should be instructed to scoot to the phone using the buttocks on the uninjured side.
D) One option is to crawl to a stairway and use the stairs to gradually lift the body to a standing position.
Page Ref: 973
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

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Learning Outcome: 13.C. Analyze hip fractures as they relate to mobility. Compare the risk factors for and prevention of hip fractures.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with a hip fracture.

2) The nurse is assessing an older adult client in a long-term care facility after a fall. Which finding requires priority action?

A) The injured leg is shortened and externally rotated.
B) Redness and severe swelling are found at the hip joint.
C) Pain is relieved by moving the affected extremity.
D) The client is repeatedly flexing the injured leg at the hip.

Answer: A

Explanation: A) The client with a fractured hip is often in extreme pain and assumes a position with the leg on the affected side shortened and externally rotated because of gravity and the pull of the muscles.

B) Redness and swelling are the classic signs of inflammation not immediately present after hip fracture.

C) Any movement of the leg on the side of the affected hip is likely to cause severe muscle spasms and further pain. Pain being relieved by movement would not be a priority.

D) Extreme pain associated with hip fracture prevents any voluntary movement in the leg. Being able to flex the injured leg at the hip would not be a priority.

Page Ref: 974

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 13.C. Analyze hip fractures as they relate to mobility. Identify the clinical manifestations of hip fractures.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with a hip fracture.

3) A postmenopausal client asks the nurse what she can do to prevent fracturing her hips, as her mother and grandmother both experienced this health problem. Which response by the nurse is most appropriate?
A) "You should avoid all types of exercise."
B) "You should consider a smoking cessation program."
C) "You should limit your exposure to the sun."
D) "You should use throw rugs throughout your home."
Answer: B
Explanation: A) The client should not be instructed to avoid exercise; exercise will enhance the client's gait, balance, and musculoskeletal strength.
B) One modifiable risk factor for hip fractures is smoking. Women who smoke have a greater risk of fracture because smoking reduces bone density in menopausal and postmenopausal women.
C) Limiting sun exposure will not impact the client's risk of experiencing a hip fracture.
D) The nurse should not instruct the client to use throw rugs throughout the home because this could cause tripping, leading to a fall.
Page Ref: 973
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 13.C. Analyze hip fractures as they relate to mobility. Compare the risk factors for and prevention of hip fractures.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with a hip fracture.

4) The first day after surgery to repair a fractured hip sustained from a fall, an older adult client refuses to ambulate but states, "I will consider it tomorrow." Which action should the nurse take?
A) Coordinate personnel to assist with ambulation
B) Document the client's refusal
C) Assess why the client is refusing to ambulate
D) Notify the healthcare provider
Answer: C
Explanation: A) The nurse should not force the client to get out of bed.
B) Documenting the client's refusal is appropriate, but after determining the reason for the refusal.
C) The first thing the nurse should do is assess why the client is refusing to ambulate. The client might be fearful of falling, given that a prior fall resulted in a fractured hip. Following this assessment, the nurse could plan interventions that would facilitate ambulation, such as controlling pain and reducing the fear of falling.
D) It is premature to notify the healthcare provider.
Page Ref: 977
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 13.C. Analyze hip fractures as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with a hip fracture.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with a hip fracture.

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5) A client with a BMI of 35 is recovering from total hip replacement surgery and experiencing pain that is exacerbated with movement. The client says to the nurse, "I live alone. How will I ever be able to return to my home?" For which problem should the nurse plan care for this client?

A) Excess body weight
B) Acute pain
C) Compromised physical mobility
D) Stress overload

Answer: B

Explanation: A) Excess body weight is not the priority.

B) Unless this pain is controlled, the client will not be able to participate in care to heal after the surgery.

C) The client is recovering from surgery and will have compromised physical mobility but this isn't the reason the client is asking about care needed after discharge.

D) There is no evidence that the client is overloaded with stress.

Page Ref: 976

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 13.C. Analyze hip fractures as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with a hip fracture.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with a hip fracture.

6) An older adult client is recovering from a fractured hip and will be staying with an adult child. Which statements indicate that discharge teaching provided to the client was effective? **Select all that apply.**
A) "I have signed a contract with Lifeline."
B) "We are removing the area rugs in the hallway."
C) "I've borrowed a toilet seat riser from the equipment closet."
D) "I will be sure to take oxycodone before I go downstairs in the morning."
E) "I can help with housework while I'm staying at my child's house."
Answer: A, B, C
Explanation: A) The use of an emergency alert service would be appropriate.
B) Picking up loose area rugs can help decrease the risk of falls.
C) A toilet seat riser would be appropriate.
D) Pain medication should not be taken when there is a risk of a fall, particularly prior to going down a set of stairs.
E) Many housework tasks will be inappropriate.
Page Ref: 978
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 13.C. Analyze hip fractures as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with a hip fracture.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with a hip fracture.

7) The nurse is evaluating care provided to a client recovering from hip replacement surgery. Which documentation indicates that the client has achieved the expected outcome for pain management?

A) The client states pain is a 6 on a numeric pain scale of 0 to 10 prior to evening care.
B) The client is crying and requesting pain medication prior to morning care.
C) The client is using a PCA pump around the clock and rates pain as a 2 on a numeric pain scale of 0 to 10.
D) The client refuses pain medication prior to physical therapy. Pain is rated as a 7 on a numeric pain scale of 0 to 10.

Answer: C

Explanation: A) A pain rating of 6 on a scale of 0 to 10 does not indicate that pain is being effectively managed.

B) Crying and requesting pain medication does not indicate pain is being managed.

C) Using the PCA pump and having a pain rating of 2 on a 0-to-10 scale indicates pain is being managed.

D) A pain level of 7 on a scale of 0 to 10 does not indicate effective pain management.

Page Ref: 977

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 13.C. Analyze hip fractures as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with a hip fracture.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with a hip fracture.

8) An older adult client experiences a hip fracture. Which surgical procedure should the nurse anticipate?
A) Total hip replacement
B) Open reduction and external fixation
C) Arthroplasty
D) Open reduction and internal fixation
Answer: D
Explanation: A) A total hip replacement is generally performed only when severe arthritis or an underlying bone condition is present.
B) Open reduction and external fixation is not a surgical option for a fractured hip.
C) Arthroplasty is generally performed only when severe arthritis or an underlying bone condition is present.
D) Open reduction and internal fixation is the preferred surgical procedure to repair a fractured hip for older adult clients.
Page Ref: 975
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 13.C. Analyze hip fractures as they relate to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a hip fracture.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with a hip fracture.

9) A client is recovering from surgery to repair a fractured hip. Which actions by the nurse may reduce this client's risk for osteomyelitis in the postoperative period? **Select all that apply.**
A) Assess for pain every 1-2 hours.
B) Use sterile technique for dressing changes.
C) Assess wound for size, color, and drainage.
D) Administer antibiotics as prescribed.
E) Administer anticoagulants as prescribed.
Answer: B, C, D
Explanation: A) Assessing for pain every 1-2 hours is appropriate for pain management.
B) Interventions that can reduce the client's risk for infection include using sterile technique for dressing changes.
C) Interventions that can reduce the client's risk for infection include assessing the wound for size, color, and drainage.
D) Interventions that can reduce the client's risk for infection include administering antibiotics as prescribed.
E) Administering anticoagulants reduces the risk for deep vein thrombosis (DVT).
Page Ref: 977
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 13.C. Analyze hip fractures as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with a hip fracture.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with a hip fracture.

10) A client having surgery for a fractured hip will receive careful attention to preserve the epiphyseal plate. Which client will require this precaution during surgery?
A) A postmenopausal client with paraplegia
B) A 32-year-old male who is a competitive body builder
C) A prepubescent female who is a vegetarian
D) An 85-year-old client with osteoporosis
Answer: C
Explanation: A) Epiphyseal plates are not an issue for a postmenopausal client with paraplegia.
B) Epiphyseal plates are not an issue for a 32-year-old client.
C) Epiphyseal plates are unique joints that produce growth of bone length in children. There is an epiphyseal plate that lies between the head and neck of the femur that must be preserved during hip surgery in pediatric clients to prevent obstruction of bone growth. The prepubescent female is young enough to have an epiphyseal plate.
D) Epiphyseal plates are not an issue for an 85-year-old client.
Page Ref: 976
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.C. Analyze hip fractures as they relate to mobility. Differentiate considerations for care of patients with hip fractures across the lifespan.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with a hip fracture.

11) An adult client is recovering from an open reduction and internal fixation of a fractured hip. Which statement indicates that discharge teaching provided to this client was effective? **Select all that apply.**

A) "I will use my abduction pillow while sleeping to maintain proper hip alignment."
B) "I will use a high toilet seat to prevent excess flexion of my hip."
C) "I only need to use my walker during physical therapy appointments."
D) "I will take my prescribed ibuprofen to decrease the risk for deep vein thrombosis."
E) "I might experience bruising because of the warfarin I've been prescribed."
Answer: A, B, E
Explanation: A) The client should be instructed to use an abduction pillow.
B) The client should be instructed to use a high toilet seat to prevent excessive hip flexion.
C) The nurse should remind the client to use the walker at all times until told otherwise.
D) Warfarin, not ibuprofen, is prescribed to decrease the risk for deep vein thrombosis.
E) The client should be instructed that warfarin increases the risk for bruising.
Page Ref: 977
Cognitive Level: Evaluating
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 13.C. Analyze hip fractures as they relate to mobility. Apply the nursing process in providing culturally competent care to an individual with a hip fracture.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with a hip fracture.

12) In which way would the nurse categorize a hip fracture that occurs in the trochanter region?
A) Intracapsular
B) Intercapsular
C) Extracapsular
D) Subcapsular
Answer: C
Explanation: A) Intracapsular hip fractures occur at the femoral head and neck within the capsule of the hip joint.
B) The term *intercapsular* is not used to describe a fracture of the hip.
C) Extracapsular hip fractures occur within the trochanter region, which is between the neck and diaphysis of the femur.
D) *Subcapsular* is not used to describe a fracture of the hip.
Page Ref: 928
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.C. Analyze hip fractures as they relate to mobility. Describe the pathophysiology of hip fractures.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with a hip fracture.

13) For non-elderly adult clients who fracture a hip, for which reason is internal fixation or casting of the fracture generally preferred over hip replacement?
A) Internal fixation or casting is preferred because it does not disturb the client's epiphyseal plate.
B) Internal fixation or casting is preferred because of the lower risk of deep vein thrombosis.
C) Internal fixation or casting is preferred because of the shorter recovery time.
D) Internal fixation or casting is preferred because of the limited longevity of hip prostheses.
Answer: D
Explanation: A) Protection of the epiphyseal plate is not a concern in adult clients, because they no longer have epiphyseal plates.
B) Internal fixation has the same risk of deep vein thrombosis and other surgical approaches.
C) Internal fixation has the same recovery time as other surgical approaches.
D) Non-elderly adults are likely to live beyond the decade or so anticipated lifespan of a replacement hip. Internal fixation and casting are the preferred treatment methods for these clients because hip replacement may eventually necessitate revision surgery, which carries a greater level of risk than the initial hip replacement surgery.
Page Ref: 975
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 13.C. Analyze hip fractures as they relate to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a hip fracture.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with a hip fracture.

Exemplar 13.D Multiple Sclerosis

1) A client with multiple sclerosis has an acute onset of visual changes, fatigue, and leg weakness. The client states that the last time this happened, recovery occurred in a few weeks. Which classification of multiple sclerosis is the client experiencing?
A) Progressive-relapsing
B) Secondary-progressive
C) Relapsing-remitting
D) Primary-progressive
Answer: C
Explanation: A) Progressive-relapsing MS involves a steady worsening of disease with acute relapses.
B) Secondary-progressive MS begins as relapsing-remitting but becomes worse between exacerbations.
C) Relapsing-remitting MS is characterized by clearly defined flare-ups with worsening neurological function followed by periods of partial or complete remission with few or no symptoms.
D) Primary-progressive MS involves slow but nearly continuous worsening of the disease from the time of onset with no distinct remissions.
Page Ref: 980
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Identify the clinical manifestations of MS.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

2) A young adult client complains of blurred vision and muscle spasms that have come and gone over the past several months. The physician suspects that the client has multiple sclerosis. Which information in the client's history would the nurse recognize as a risk factor for MS?
A) Male sex
B) Native American descent
C) Lives north of the equator
D) Takes a vitamin D supplement daily
Answer: C
Explanation: A) Risk factors for MS include being female.
B) There is no evidence that Native American descent increases the risk for MS.
C) Individuals who live farther from the equator and are exposed to less sunlight are more likely to develop MS.
D) Taking a vitamin D supplement may decrease the risk.
Page Ref: 980
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Compare the risk factors for and prevention of MS.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

3) A client with a history of relapsing-remitting multiple sclerosis (MS) is pregnant with a first child. Which intervention would be indicated for this client?
A) Suggest the client seek reproductive counseling.
B) Tell the client to expect a period of remission after delivery.
C) Instruct the client to expect an exacerbation of symptoms while pregnant.
D) Discuss the client's options for pain control during labor, as contractions will be especially severe.
Answer: A
Explanation: A) A definite genetic cause of MS has not been established; however, studies suggest that genetic factors make some individuals more susceptible to the disorder than others. Also, some medications used in the treatment of MS can be harmful to a fetus. Because of this, reproductive counseling would be recommended for this client.
B) There is a slightly increased relapse rate postpartum.
C) Pregnancy often brings about remission (not exacerbation) of MS.
D) The strength of uterine contractions in a client with MS is not severe, and because clients often have lessened sensation, labor may be almost painless.
Page Ref: 986
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Differentiate considerations for care of patients with MS across the lifespan.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

4) A client with relapsing-remitting multiple sclerosis (MS) reports leg spasms and blurred vision; however, the greatest issue is being tired. Which problem should the nurse use to plan care for this client?
A) Fatigue
B) Inadequate coping skills
C) Inadequate role performance
D) Inability to perform self-care
Answer: A
Explanation: A) Because the client reports feeling tired, the problem of fatigue would be the priority.
B) There is no evidence that the client is unable to cope with being tired.
C) There is no evidence that the client is unable to perform expected roles.
D) There is no evidence that the client is unable to perform self-care because of being tired.
Page Ref: 987
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with MS.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

5) A client with multiple sclerosis is frustrated with eating because of hand and arm spasms that prevent the proper use of utensils. Which intervention should the nurse implement to best assist this client?
A) Consult with the occupational therapist regarding assistive devices for meals.
B) Counsel the client to select finger foods for meals.
C) Plan time to feed the client.
D) Consult with the physical therapist regarding hand and arm exercises.
Answer: A
Explanation: A) Because the ability to feed oneself is essential to positive self-concept and self-esteem, the nurse should consult with the occupational therapist regarding devices the client can use to maintain independence at mealtimes.
B) The nurse should not counsel the client to select finger foods for meals.
C) The nurse should not feed the client.
D) The nurse might consult the physical therapist regarding hand splints, but hand and arm exercises might not be beneficial for this client.
Page Ref: 988
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with MS.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

6) A client with multiple sclerosis (MS) is observed transferring from the bed to a motorized wheelchair and applying splints to the lower extremities before entering the bathroom to perform morning self-care. Which conclusion should the nurse make regarding this observation?
A) The client uses assistive devices to optimize autonomy.
B) The client should be instructed to conduct morning care before applying splints to the lower extremities.
C) The client is dependent on assistive devices.
D) The client should be advised to avoid use of a motorized wheelchair when possible.
Answer: A
Explanation: A) The nurse observed the client independently transfer from the bed to a motorized wheelchair, apply splints, and enter the bathroom to perform morning self-care. This is evidence that the client uses assistive devices to optimize autonomy.
B) Applying the splints supports independence with morning care.
C) The assistive devices support the client's independence.
D) The wheelchair supports the client's independence.
Page Ref: 988
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with MS.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

7) A client with multiple sclerosis is prescribed diazepam (Valium). Which assessment finding indicates that this medication is effective for the client?
A) Muscle spasticity is reduced.
B) Blood glucose level is within normal limits.
C) The client states that muscles are weak.
D) Ophthalmologic examination shows no evidence of cataracts.
Answer: A
Explanation: A) Diazepam (Valium) is a muscle relaxant commonly used for clients with multiple sclerosis. Evidence of medication effectiveness would be an observed reduction in muscle spasticity.
B) Glucose intolerance would be assessed if the client were prescribed an adrenal corticosteroid. Cataract development is also a side effect of adrenal corticosteroids.
C) Diazepam (Valium) does not cause muscle weakness.
D) Cataract development is a side effect of adrenal corticosteroids.
Page Ref: 944
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with MS.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

8) The nurse is planning care for a client with multiple sclerosis. Which intervention would address the problem of fatigue?
A) Encourage increased activity.
B) Schedule physical therapy three times a day.
C) Plan activities with sufficient rest periods between them.
D) Group activities together so care will not be interrupted.
Answer: C
Explanation: A) Interventions to address fatigue include assisting the client in setting priorities regarding activities.
B) Physical therapy three times a day may be too aggressive for this client.
C) Interventions to address fatigue include arranging activities to include rest periods between them.
D) Activities should not be grouped together.
Page Ref: 988
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with MS.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

9) The nurse is caring for several clients from various cultural backgrounds. Which client would the nurse assess as having the highest risk for multiple sclerosis?
A) A Brazilian woman with chronic parasitic infestation
B) A Hispanic man with colonized methicillin-resistant *Staphylococcus aureus* (MRSA)
C) A Northern Canadian woman who has smoked for 25 years
D) An African man in his 20s who has a vitamin D deficiency
Answer: C
Explanation: A) Factors that lower the risk of MS include living closer to the equator (as is the case for the Brazilian client).
B) Factors that lower the risk of MS include being male.
C) The Northern Canadian woman who smokes has three risk factors for MS: female gender, living farthest from the equator, and smoking.
D) Factors that lower the risk of MS include being male.
Page Ref: 980
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Compare the risk factors for and prevention of MS.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

10) An adult client recently diagnosed with multiple sclerosis (MS) reports engaging in vigorous exercise on a regular basis. Which statements contain the correct information to give this client when answering specific questions about lifestyle? **Select all that apply.**
A) "Hyperbaric oxygen treatment is recommended prior to vigorous physical exercise."
B) "You will tolerate exercise better in an air-conditioned room."
C) "Acupuncture may benefit some of your symptoms."
D) "Drinking cold water is recommended during exercise."
E) "You will be able to maintain your current exercise schedule."
Answer: B, C, D
Explanation: A) Hyperbaric oxygen therapy carries more risk than benefit.
B) Exercising in a cold room helps keep body temperature down.
C) Acupuncture has low risk and may be beneficial for some symptoms of MS.
D) Drinking cold beverages help keep body temperature down.
E) It is unlikely that a newly diagnosed client with MS will be able to tolerate regular vigorous exercise.
Page Ref: 986
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with MS.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

11) During an outpatient clinic follow-up appointment, a client with multiple sclerosis (MS) has lab tests completed. The results show elevated levels of aspartate aminotransferase (AST), serum glutamic-oxaloacetic transaminase (SGOT), alanine aminotransferase (ALT), serum glutamic-pyruvic transaminase (SGPT), and alkaline phosphatase (ALP). The nurse recognizes that these elevated enzyme levels are a potential adverse effect of which medications? **Select all that apply.**
A) Interferon beta-1a (Avonex)
B) Teriflunomide (Aubagio)
C) Glatiramer acetate (Copaxone)
D) Mitoxantrone (Novantrone)
E) Fingolimod (Gilenya)
Answer: A, B
Explanation: A) AST, SGOT, ALT, SGPT, and ALP are liver enzymes that are monitored to detect adverse responses to interferon beta-1a (Avonex).
B) AST, SGOT, ALT, SGPT, and ALP are liver enzymes that are monitored to detect adverse responses to teriflunomide (Aubagio).
C) Glatiramer acetate (Copaxone) does not affect the liver.
D) Mitoxantrone (Novantrone) does not affect the liver.
E) Fingolimod (Gilenya) does not affect the liver.
Page Ref: 984
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with MS.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

WwW.TeSt.Ws

12) The nurse is teaching the parents of a client who was recently diagnosed with multiple sclerosis (MS) about what to expect as their child's condition progresses. Which statement by the parents indicates the need for further instruction?
A) "My child is at increased risk for seizures because of the MS diagnosis."
B) "It's not unusual for kids with MS to have problems with their schoolwork."
C) "MS usually progresses faster in children than in adults."
D) "Making friends may be more difficult for our child because of the MS."
Answer: C
Explanation: A) Children with MS often experience seizures related to the diagnosis.
B) Children with MS often have reduced academic performance.
C) MS usually progresses more slowly in children than in adults.
D) Children with MS often experience difficulty in family and peer relationships.
Page Ref: 986
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Differentiate considerations for care of patients with MS across the lifespan.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

13) Which category of multiple sclerosis (MS) is characterized by a slow but nearly continuous worsening of the disease from the time of onset with no distinct remissions?
A) Relapsing-remitting
B) Progressive-relapsing
C) Primary-progressive
D) Secondary-progressive
Answer: C
Explanation: A) Relapsing-remitting MS is characterized by clearly defined flare-ups with worsening neurological function followed by periods of partial or complete remission with few or no symptoms.
B) Progressive-relapsing MS involves a steady worsening of disease with acute relapses.
C) Primary-progressive MS involves slow but nearly continuous worsening of the disease from the time of onset with no distinct remissions.
D) Secondary-progressive MS begins as relapsing-remitting but becomes worse between exacerbations.
Page Ref: 980
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Identify the clinical manifestations of MS.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

14) Which assessment finding would be classified as a secondary symptom of multiple sclerosis (MS)?
A) Pressure sores
B) Urinary retention
C) Depression
D) Unsteady gait
Answer: A
Explanation: A) Because pressure sores result from primary symptoms such as muscle weakness and inability to ambulate, they would be considered a secondary symptom.
B) Urinary retention is a primary symptom of MS.
C) Depression is a tertiary symptom (because it involves a psychosocial problem).
D) Unsteady gait is a primary symptom of MS.
Page Ref: 981
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Identify the clinical manifestations of MS.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

15) Which information about symptoms indicates that a client with multiple sclerosis (MS) is experiencing an exacerbation?
A) Last at least 1 week and are separated from a previous attack by at least 30 days
B) Last at least 24 hours and are separated from a previous attack by at least 30 days
C) Last at least 2 weeks and are separated from a previous attack by at least 2 months
D) Last at least 30 days and are separated from a previous attack by at least 2 months
Answer: B
Explanation: A) A true exacerbation does not last for a week.
B) A true exacerbation must last at least 24 hours and must be separated from the previous attack by at least 30 days.
C) A true exacerbation does not last for 2 weeks.
D) A true exacerbation does not last for 30 days.
Page Ref: 981
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Identify the clinical manifestations of MS.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

16) Which medication is used to treat tertiary symptoms of multiple sclerosis (MS)?
A) Bupropion
B) Ciprofloxacin
C) Magnesium hydroxide
D) Glatiramer
Answer: A
Explanation: A) Tertiary symptoms of MS relate to psychosocial problems, such as relationship difficulties, loss of a job because of decreased performance, or hopelessness. Bupropion (an antidepressant) would be used to treat a tertiary symptom (depression).
B) Ciprofloxacin (an antibiotic) would be used to treat the secondary symptoms of infection.
C) Magnesium hydroxide (a laxative) would be used to treat the secondary symptoms of constipation.
D) Glatiramer (Copaxone) would be used to treat the primary symptoms of MS.
Page Ref: 985
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 13.D. Analyze multiple sclerosis (MS) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with MS.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with multiple sclerosis.

Exemplar 13.E Osteoarthritis

1) The nurse is providing teaching to the client recently diagnosed with osteoarthritis. Which statement by the nurse is correct?
A) "Osteoarthritis is most commonly seen in thin, small-built female clients."
B) "Osteoarthritis is a result of joint inflammation."
C) "Osteoarthritis occurs due to erosion of cartilage in the joints."
D) "Osteoarthritis is a metabolic bone disease."
Answer: C
Explanation: A) Thin, small-built female clients are at increased risk for osteoporosis, not osteoarthritis.
B) Joint inflammation is a characteristic of rheumatoid arthritis, not osteoarthritis.
C) Osteoarthritis is characterized by progressive erosion of the cartilage within joints.
D) Osteoarthritis is not a metabolic bone disease; examples of such diseases include osteoporosis, osteomalacia, and Paget disease.
Page Ref: 991
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Describe the pathophysiology of OA.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

2) The nurse is caring for a client with osteoarthritis. Which factor in the client's history and physical assessment would the nurse recognize as a risk factor for developing this condition?
A) Body mass index of 36.5
B) History of esophageal reflux disease
C) Client plays tennis three times each week
D) Blood pressure of 136/78 mmHg
Answer: A
Explanation: A) Obesity increases the risk of developing osteoarthritis (OA), because the added weight increases stress on weight-bearing joints, causing the joints to wear down more quickly. This client has a body mass index of 36.5, which is considered obese.
B) Esophageal reflux is not associated with OA.
C) Moderate recreational exercise (such as tennis three times per week) has been shown to decrease the chance of developing OA and slow the progression of manifestations when OA is present.
D) Blood pressure is not a known risk factor for the development of OA.
Page Ref: 991
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Compare the risk factors for and prevention of OA
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

3) An older adult client with bilateral osteoarthritis of the knees tells the nurse, "I know I need to lose weight, but exercising makes my knees ache." Which instruction should the nurse provide to this client?
A) "You should discuss knee replacement surgery with your physician."
B) "Exercising the muscles in your legs might be hard now, but over time, it will help protect your knees."
C) "Try eating a reduced-calorie diet for several months before attempting exercise."
D) "You need to stretch your muscles, because stretching is the only form of exercise that improves osteoarthritis."
Answer: B
Explanation: A) The client may or may not want to have knee replacement surgery.
B) Encouraging exercise is an important aspect of nursing care for clients with osteoarthritis (OA). Exercise can increase flexibility, improve blood flow, and help clients lose weight. Over time, these factors can help protect the joints against further deterioration and pain.
C) The nurse should not counsel the client to follow a reduced-calorie eating plan for several months before attempting exercise.
D) Stretching is just one type of exercise that will benefit clients with OA. The other components, strengthening and aerobic exercise, can be obtained through walking, swimming, and isometric, isotonic, and resistive exercises.
Page Ref: 991
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Compare the risk factors for and prevention of OA.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

WwW.TeSt.Ws

4) The nurse is planning care for a client with osteoarthritis (OA). Which problem would have the highest priority?
A) Fatigue
B) Chronic pain
C) Difficulty with coping
D) Altered body image
Answer: B
Explanation: A) Fatigue is not an identified problem for a client with OA.
B) The client with OA will experience pain that may become progressively worse. The problem of chronic pain should be the priority.
C) There is no evidence that the client is having difficulty coping.
D) There is no evidence that the client has a problem with body image.
Page Ref: 996
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with OA.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

5) The nurse is planning care for a client with osteoarthritis of the hip. Which intervention would be appropriate for this client?
A) Provide moist heat packs to the affected joint 3 times each day.
B) Instruct the client on the importance of strict bedrest.
C) Provide nonsteroidal anti-inflammatory drugs (NSAIDs) when pain becomes severe.
D) Provide opioid pain medication as prescribed.
Answer: A
Explanation: A) Interventions appropriate for a client with osteoarthritis (OA) include NSAIDs, moist heat, active range-of-motion exercises, proper posture and body mechanics, and assistive devices to safely maintain independence with activities of daily living.
B) The client should be encouraged to be mobile, not on strict bedrest.
C) NSAIDs are most effective if taken before the pain is severe.
D) Opioid medication is not typically prescribed for the treatment of OA.
Page Ref: 992
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with OA.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

6) The nurse is evaluating care provided to a client with osteoarthritis (OA). Which client statement indicates to the nurse that interventions for OA have been successful?
A) "I had to take early retirement and now stay at home all day and rest my legs."
B) "I am sleeping throughout the night and have not missed any work because of knee pain."
C) "I am moving from my two-story house into the first floor of my daughter's home so I won't have to walk steps anymore."
D) "I changed my work hours so now I work part time and have a nursing assistant who helps me bathe twice a week at home."
Answer: B
Explanation: A) A client who retires early and stays at home all day is also experiencing a significant impact in lifestyle.
B) Expected outcomes for the care of a client with OA include independence with activities of daily living, minimal lifestyle impact because of OA, and controlled pain that allows for rest and sleep. Of the client statements provided, only the one about improved sleep and pain not interfering with work indicates achievement of these outcomes.
C) A client who is moving in with a daughter is experiencing significant lifestyle impact.
D) A client who changes work hours and has a nursing assistant for bathing is experiencing a reduction in activities of daily living and a significant impact in lifestyle.
Page Ref: 997
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with OA.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

7) A client with osteoarthritis tells the nurse she has difficulty walking to the bathroom first thing in the morning. Which nursing action would assist this client?
A) Suggesting a family member provide the client with a bedpan
B) Discussing the option of residing in an assisted-living facility
C) Consulting with physical therapy for an assistive walking device such as a walker or cane
D) Suggesting the client use a bedside commode at home
Answer: C
Explanation: A) The use of a bedpan may help with the immediate need to use the bathroom, but the client will still have difficulty ambulating in the morning.
B) The option of residing in an assisted-living facility might be premature for this client.
C) Assistive devices are items used to maintain, increase, or improve function. The client describes difficulty walking to the bathroom in the morning. The best intervention to help this client would be to consult with physical therapy for an assistive walking device such as a walker or cane.
D) The use of a bedside commode may help with the immediate need to use the bathroom, but the client will still have difficulty ambulating in the morning.
Page Ref: 997
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with OA.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

WwW.TeSm.Us

8) A client with chronic hip pain is diagnosed with osteoarthritis. Which instruction regarding home safety is most appropriate for the nurse to provide to this client?

A) Walk up and down the steps at home as much as possible.

B) Rest in a recliner.

C) Place scatter rugs in high-traffic areas.

D) Install grab bars in the bathroom near the commode and in the shower.

Answer: D

Explanation: A) The client should be instructed not to overuse the affected joints with excessive stair climbing.

B) The client should also be instructed to sit in a straight-back chair, avoid slumping, and avoid use of a recliner.

C) Scatter rugs are a hazard to mobility and should be avoided.

D) The client should be encouraged to install grab bars in the bathroom near the commode and in the shower.

Page Ref: 997

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with OA.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

9) A client seeking treatment for severe knee pain has worked in a factory for 30 years in a position requiring repetitive lifting and carrying of 20- to 40-pound boxes. Based on the client's history, the nurse should anticipate which initial recommendation from the interprofessional healthcare team?

A) Joint replacement surgery
B) Pharmacologic therapy
C) Referral for a disability application
D) Intermittent use of a cane

Answer: B

Explanation: A) Joint replacement should be delayed as long as possible because artificial joints often require replacement within 15-20 years.

B) Pharmacologic therapy would be the most likely initial intervention. Acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), and joint injections are all possible options.

C) There is not enough information to determine whether applying for disability is appropriate at this time.

D) A cane is not indicated at this time.

Page Ref: 994

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with OA.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

10) A client with limited joint pain had synovial fluid analysis completed. Which response should the nurse make when asked what it means when the fluid has no uric acid crystals or bacteria?
A) "These test results mean that your joint pain is likely not caused by gout or septic arthritis."
B) "These test results mean that your joint pain is likely not related to any form of arthritis."
C) "These test results mean that your joint pain is likely caused by either rheumatoid arthritis or septic arthritis."
D) "These test results mean that your joint pain is likely caused by either cancer of the joint or gout."
Answer: A
Explanation: A) Gout is caused by the collection of uric acid crystals in a joint. The absence of uric acid crystals in the synovial fluid (joint fluid) makes gout unlikely. Septic arthritis is caused by infection, so the absence of bacteria makes sepsis unlikely.
B) This test does not rule out any form of arthritis.
C) This test does not rule out rheumatoid arthritis.
D) Although the nurse may provide information related to which conditions have been ruled out, providing a medical diagnosis is outside the nurse's scope of practice.
Page Ref: 993
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with OA.
MNL LO: Analyze the concept of mobility and its application to nursing care.

11) A client with osteoarthritis (OA) of the knees and hips returns for a 3-month follow-up visit with the provider. The nurse calculates that the client's body mass index (BMI) is now 22. The client reports starting a water aerobics and running program three times per week. The client is also using hot packs for edema for 20 minutes and cold packs for pain for 40 minutes daily. After evaluating the client's actions, which follow-up interventions should the nurse plan? **Select all that apply.**
A) Reinforce the correct use of hot packs.
B) Suggest the client replace running with a lower impact exercise.
C) Explain the risk of injury associated with use of cold packs.
D) Advise the client to continue weight loss.
E) Congratulate the client on starting water aerobics.
Answer: A, B, C, E
Explanation: A) The nurse should reinforce that hot packs are used to decrease pain.
B) The nurse should suggest that the client replace the high impact exercise of running with a lower impact exercise such as walking or biking.
C) The client should be informed that using cold packs for more than 30 minutes may cause skin injury.
D) The nurse should congratulate the client on the weight loss. Note, however, that a BMI of 22 is ideal, so continued weight loss should not be encouraged.
E) The nurse should congratulate the client on starting water aerobics because it is a low-impact exercise mode.
Page Ref: 992
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with OA.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

12) The nurse is teaching the parents of a client who was recently diagnosed with osteoarthritis (OA) about their child's condition. Which statement by the parents indicates the need for further instruction?

A) "Our daughter's OA is likely related to a joint injury she sustained last year."

B) "Most kids with OA usually have only one or two affected joints."

C) "Because our daughter developed OA as a child, she is more likely to become disabled as a result of this condition."

D) "Our daughter may outgrow her OA as she ages."

Answer: C

Explanation: A) Juvenile OA is usually secondary to a congenital abnormality, genetic condition, or joint injury.

B) Juvenile OA typically occurs only in the one or two joints affected by the abnormality or injury.

C) Children with OA are less likely to become disabled.

D) Children with OA may outgrow the condition as they age. Further instruction is not needed.

Page Ref: 996

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Differentiate considerations for care of patients with OA across the lifespan.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

13) Which treatment option would least likely be considered for a 71-year-old client with osteoarthritis (OA)?
A) Physical therapy
B) Administration of nonsteroidal anti-inflammatory drugs (NSAIDs)
C) Weekly tai chi sessions
D) Administration of narcotics
Answer: B
Explanation: A) Physical therapy is especially important in older adults to maintain or improve mobility of joint(s).
B) NSAIDs can create problems for older adults due to their effects on the kidneys.
C) Complementary health approaches such as tai chi may assist older adults in increasing mobility and reducing pain levels.
D) Narcotics are a second-line choice, because they are safer than NSAIDs for older adults.
Page Ref: 996
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Differentiate considerations for care of patients with OA across the lifespan.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

14) Which procedure used in the treatment of osteoarthritis (OA) involves removing a small amount of bone at the articulating surface of the joint and fitting a metal replacement over the end of the bone?
A) Osteotomy
B) Arthroplasty
C) Arthroscopy
D) Joint resurfacing
Answer: D
Explanation: A) Osteotomy involves surgical removal of a wedge of bone above or below the joint to realign the joint and shift the weight away from the damaged portion of the joint.
B) Arthroplasty is total joint replacement, in which a surgeon removes the damaged joint surfaces and replaces them with plastic, metal, or ceramic prostheses.
C) Arthroscopy entails insertion of a small fiber optic light source, magnifying lens, and camera into the joint to visualize the joint structures.
D) In joint resurfacing, a small amount of bone is removed at the articulating surface of the joint and a metal replacement is fitted over the end of the bone.
Page Ref: 993
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with OA.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

15) Which term is used to describe osteoarthritis (OA) that is caused by an underlying condition, such as injury, congenital malformation, or metabolic disease?
A) Idiopathic
B) Secondary
C) Localized
D) Generalized
Answer: B
Explanation: A) Secondary OA is caused by an underlying condition, such as injury; congenital malformation; metabolic, endocrine, or neuropathic disease; or other medical cause.
B) Secondary OA is caused by an underlying condition, such as injury; congenital malformation; metabolic, endocrine, or neuropathic disease; or other medical cause.
C) Idiopathic OA can be further divided into localized which affects one or two joints.
D) Idiopathic OA can be further divided into generalized which affects three or more joints.
Page Ref: 991
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Describe the etiology of OA.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

16) Which procedure would be most appropriate to repair a finger joint that is affected by severe osteoarthritis (OA)?
A) Osteotomy
B) Joint resurfacing
C) Joint fusion
D) Internal fixation
Answer: C
Explanation: A) Osteotomy is usually performed on the knee and hip and entails surgical removal of a wedge of bone above or below the joint to realign the joint and shift the weight away from the damaged portion of the joint.
B) Joint resurfacing, which involves removing a small amount of bone at the articulating surface of the joint and fitting a metal replacement over the end of the bone, is often performed for hip and shoulder joints.
C) Joint fusion is used to permanently fuse two or more bones together at a joint using pins, plates, screws, and rods. It is often recommended for badly damaged smaller joints, such as the spine, wrist, ankle, finger, or toe.
D) Internal fixation is used to fix fractures, not to address osteoarthritis.
Page Ref: 993
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with OA.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

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17) Clients with osteoarthritis (OA) can reduce their risk of further joint damage by doing which action?
A) Applying topical analgesic creams as prescribed
B) Avoiding movement of affected joints
C) Taking acetaminophen or nonsteroidal anti-inflammatory drugs (NSAIDs) before joint pain becomes severe
D) Receiving cortisone injections in affected joints no more than three times per year
Answer: D
Explanation: A) Applying topical analgesics reduces the pain of OA but does not reduce the risk of further joint damage.
B) Avoiding movement of affected joints does not reduce the risk of joint damage; rather, it worsens the effects of OA.
C) Taking acetaminophen and NSAIDs reduces the pain of OA but does not reduce the risk of further joint damage.
D) Because frequent use of corticosteroids can cause joint damage, clients should receive cortisone injections in affected weight-bearing joints no more than three or four times per year.
Page Ref: 995
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 13.E. Analyze osteoarthritis (OA) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with OA.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with osteoarthritis.

Exemplar 13.F Parkinson Disease

1) A client complains of a right-hand tremor, increasing weakness, and muscles that feel tight. The nurse notes that the client has poor voice volume and facial muscles that do not move easily. The nurse recognizes that these symptoms are consistent with which condition?
A) Parkinson disease
B) Spinal cord injury
C) Cerebrovascular accident
D) Multiple sclerosis
Answer: A
Explanation: A) Manifestations of Parkinson disease include unintentional tremor, slowed movements, low amplitude of speech, expressionless face, and muscle rigidity. The client is complaining of or exhibiting all these symptoms, suggesting a diagnosis of Parkinson disease.
B) These symptoms are not manifestations of spinal cord injury.
C) These symptoms are not manifestations of a cerebrovascular accident.
D) These symptoms are not manifestations of multiple sclerosis.
Page Ref: 99
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility. Identify the clinical manifestations of PD.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

2) A middle-aged female client says, "I have noticed a slight tremor in my left hand when it's at rest. I think I might have Parkinson disease because my mother had it." Which response by the nurse is the most appropriate?
A) "Having a close relative with Parkinson disease can increase your chance of developing it as well."
B) "You shouldn't worry too much, because Parkinson disease has a higher prevalence in males."
C) "It is unlikely that you have the same illness as your mother."
D) "You probably don't have Parkinson disease. Your mother was probably exposed to a toxin that caused her illness."
Answer: A
Explanation: A) Approximately 30% of the risk for PD is explained by genetics. Individuals with a first-line family member have a 2-3% increased risk of developing PD.
B) Men are at higher risk for PD, with 50% more men than women developing the disease, but this does not eliminate the client's risk of having the disease, especially given her mother's diagnosis.
C) The nurse should not tell the client it is unlikely she has the same illness as her mother.
D) Exposure to toxins is one theory for the development of the illness; however, the nurse has no way of knowing whether the client's mother was exposed to toxins or if that was the cause for her disease.
Page Ref: 999
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility. Compare the risk factors for and prevention of PD.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

3) A client with Parkinson disease (PD) ambulates with a shuffling gait and leans slightly forward. When seated, the client conducts a conversation, reads, and is able to self-feed without assistance. Which problem is a priority for this client?
A) Potential for falls
B) Compromised physical mobility
C) Impaired swallowing
D) Fear
Answer: B
Explanation: A) There is no evidence that the client has a potential for falls.
B) The client demonstrates a shuffled gait with forward leaning when ambulating. When seated, the client is able to converse, read, and self-feed. The problem with the highest priority would be compromised physical mobility.
C) There is no evidence that the client has impaired swallowing.
D) There is no evidence that the client has fear.
Page Ref: 1006
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with PD.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

4) The nurse is planning care for a client with Parkinson disease (PD). Which nursing intervention for the spouse would best support the client's continued mobility?
A) Suggesting that the spouse use a blender to make foods easier for the client to swallow
B) Reviewing the client's medication administration schedule with the spouse
C) Instructing the spouse to ambulate the client at least four times a day
D) Instructing the spouse on proper turning and repositioning techniques
Answer: C
Explanation: A) Blending foods to aid with swallowing would not support physical mobility.
B) Reviewing the medication administration schedule would not support physical mobility.
C) Because exercise fosters not just mobility but also independence and self-esteem, the intervention that would be most appropriate is for the nurse to instruct the spouse to ambulate the client at least four times a day.
D) Instructing on turning and repositioning techniques would not support physical mobility.
Page Ref: 1007
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with PD.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

5) The nurse is evaluating the care of a client with Parkinson disease (PD). Which finding indicates an improvement in the client's nutritional status?
A) The client filled out the menu card for each meal.
B) The client coughs frequently when drinking fluids.
C) The client was able to feed himself and had no weight change in 1 week.
D) The client had a 4-pound weight loss in 1 week.
Answer: C
Explanation: A) The client filling out the menu card does not indicate that the client actually consumed any of the meals.
B) If the client coughs frequently when drinking fluids, it could indicate that interventions to address nutritional status have not been effective.
C) The finding that the client was able to feed himself and had no weight change in 1 week is indicative of an improvement in nutritional status.
D) The client's losing 4 pounds in 1 week would not support an improvement in nutritional status.
Page Ref: 1008
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with PD.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

6) The spouse of a client with Parkinson disease (PD) expresses frustration about trying to communicate with the client. Which action should the nurse take to facilitate communication between the client and spouse?
A) Recommend that the client and spouse learn sign language.
B) Suggest that the spouse obtain a hearing aid.
C) Consult with speech therapy for exercises to aid the client with speech and language.
D) Suggest the client and spouse communicating by writing.
Answer: C
Explanation: A) The spouse and client do not need to learn sign language in order to communicate.
B) The spouse does not need a hearing aid.
C) The best intervention would be to consult with speech therapy for exercises to aid the client with speech and language.
D) The client may or may not be able to write because of hand tremors, so it may not be appropriate for the nurse to suggest that the client and spouse communicate via writing.
Page Ref: 1001
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with PD.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

7) The nurse instructs a client with Parkinson disease (PD) about levodopa/carbidopa. Which client statement indicates that this teaching has been effective?
A) "I should eat a high-protein diet when taking this medication."
B) "This medication can turn my urine and sweat dark.”
C) "I should take this medication with B vitamins.”
D) "Given enough time, this medication will cure my Parkinson disease."
Answer: B
Explanation: A) Clients should avoid eating protein-rich meals when taking this medication, as a high-protein diet may interfere with levodopa absorption from the GI tract.
B) A metabolite of levodopa may cause urine and sweat to be dark-colored.
C) The client should be instructed to not take vitamin products containing vitamin B_6 if taking levodopa without carbidopa.
D) There is no medication that is known to cure Parkinson disease.
Page Ref: 1003
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with PD.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

8) The nurse completes a teaching session for a young adult client who was recently diagnosed with Parkinson disease (PD). Which client statement indicates this teaching has been effective?
A) "I could have prevented PD with diet and exercise."
B) "I probably have a genetic mutation that caused my PD."
C) "My brain contains too much of a chemical called dopamine."
D) "Most people with PD first experience symptoms when they are about my age."
Answer: B
Explanation: A) Dietary intake has not been definitively linked to development of PD.
B) Early-onset PD is likely due to a genetic mutation.
C) PD is associated with decreased dopamine levels in the brain, not an excess of dopamine.
D) Increasing age is a risk factor for the disease, and diagnosis as a young adult is uncommon.
Page Ref: 999
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility.
Apply the nursing process in providing culturally competent care to an individual with PD.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

9) A client is being evaluated for Parkinson disease (PD). Which findings on the Unified Parkinson Disease Rating Scale (UPDRS) would be considered positive for PD? **Select all that apply.**

A) Diarrhea
B) Dystonia
C) Retropulsion
D) Hyperphonia
E) Festination

Answer: B, C, E

Explanation: A) Diarrhea is not a symptom of PD.
B) Positive findings for PD include dystonia (twisting and repetitive movements).
C) Positive findings for PD include retropulsion (the tendency to fall backward).
D) Hyperphonia (loud voice) is not a symptom of PD.
E) Positive findings for PD include festination (rapid walking as if trying to run).

Page Ref: 999-1001, 1006

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility. Identify the clinical manifestations of PD.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

10) The interprofessional treatment team proposes interventions to improve and maintain physical function for an adult client with Parkinson disease (PD). Which interventions should be recommended? **Select all that apply.**
A) Low-intensity treadmill training
B) Walking barefoot indoors
C) Use of resistance bands
D) Active and passive range-of-motion exercises
E) High-intensity treadmill training
Answer: A, C, D, E
Explanation: A) The nurse should encourage clients to participate in an exercise program, especially a combination of walking and strength training.
B) Use of shoes with non-slip soles is advised.
C) Any type of exercise is beneficial for clients with PD.
D) Any type of exercise including active and passive range of motion should be encouraged.
E) Treadmill training should be encouraged.
Page Ref: 1005
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a Parkinson disease.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

11) The nurse is caring for a 30-year-old female client who was recently diagnosed with Parkinson disease (PD). Which statement should the nurse include in the teaching for this client?
A) "Having the early-onset form of PD puts you at greater risk for dementia."
B) "If you get pregnant, it is highly unlikely that you will be able to carry the baby to term."
C) "Given your age, your PD is likely to progress more slowly than it does for people who develop the condition later in life."
D) "You can continue using birth control pills, because PD medications do not have an impact on their efficacy."
Answer: C
Explanation: A) Clients with early-onset PD generally have lower rates of dementia than clients who develop the disease later in life.
B) Many women with PD have successfully carried healthy babies to full term.
C) Clients with early-onset PD generally have a slower disease progression than clients who develop the disease later in life.
D) The effect of PD medication on the efficacy of birth control pills is not known, so clients should be urged to consider other forms of contraception.
Page Ref: 1006
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility.
Apply the nursing process in providing culturally competent care to an individual with PD.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

12) Which assessment finding is least likely to be associated with Parkinson disease (PD)?
A) Restless leg syndrome
B) Cogwheel rigidity
C) Malignant hypertension
D) Pill-rolling
Answer: C
Explanation: A) Restless leg syndrome occurs in PD.
B) Cogwheel rigidity occurs in PD.
C) Malignant hypertension is not a clinical manifestation of PD.
D) Pill-rolling occurs in PD.
Page Ref: 999-1000
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility. Identify the clinical manifestations of PD.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

13) In clients with Parkinson disease, increasing doses of, and long-term exposure to, levodopa can cause which condition?

A) Dyskinesia
B) Insomnia
C) Hypertension
D) Compulsive behavior
Answer: A
Explanation: A) With increasing doses and long-term exposure, levodopa usually causes dyskinesia, which may become less tolerable for the client than the symptoms of PD.
B) Insomnia is not a side effect of levodopa.
C) Hypertension is not a side effect of levodopa.
D) Compulsive behavior is a side effect of dopamine antagonists, not levodopa.
Page Ref: 1002
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with Parkinson disease.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

14) For which reason is carbidopa prescribed with levodopa in clients with Parkinson disease (PD)?

A) Carbidopa minimizes the conversion of levodopa to dopamine within the brain, thus minimizing levodopa's unwanted side effects.

B) Carbidopa enhances levodopa's conversion to dopamine throughout the body, thus intensifying levodopa's effectiveness.

C) Carbidopa prevents levodopa from converting to dopamine until it reaches the brain, thus minimizing levodopa's unwanted side effects.

D) Carbidopa prevents levodopa's conversion to dopamine in the brain, thus intensifying levodopa's effectiveness.

Answer: C

Explanation: A) Carbidopa does not minimize the conversion of levodopa to dopamine within the brain, to reduce levodopa's unwanted side effects

B) Carbidopa does not enhance levodopa's conversion to dopamine throughout the body to intensify levodopa's effectiveness.

C) Levodopa is a natural chemical that can cross the blood—brain barrier and be converted directly to dopamine in the brain. Levodopa can also be converted to dopamine outside the brain, which leads to the most common side effects of nausea and orthostatic hypotension. Therefore, levodopa is almost always given in combination with carbidopa, which prevents levodopa from converting to dopamine until it reaches the brain.

D) Carbidopa prevents levodopa's conversion to dopamine in the brain; however, it is not done to intensify levodopa's effectiveness.

Page Ref: 1002

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with PD.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

15) A client in the initial stages of Parkinson disease (PD) would most likely exhibit which symptom?
A) Bilateral rigidity
B) Unilateral tremors
C) Bilateral tremors
D) Unilateral rigidity
Answer: B
Explanation: A) Bilateral rigidity usually develops later in the course of the disease.
B) Motor symptoms associated with PD usually begin unilaterally, not bilaterally. For most clients, the earliest motor symptom is tremors.
C) Bilateral tremors develop later in the disease.
D) Rigidity usually develops later in the course of the disease.
Page Ref: 999
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.F. Analyze Parkinson disease (PD) as it relates to mobility. Identify the clinical manifestations of PD.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with Parkinson disease.

Exemplar 13.G Spinal Cord Injury

1) An adolescent is brought into the emergency department (ED) with injuries sustained from a motor vehicle crash. Which goal is a priority while providing nursing care for this client?
A) Adequate urine output
B) Stable blood pressure
C) Continued stabilization of the neck and spinal cord
D) Insertion of an intravenous access line
Answer: C
Explanation: A) Assessment of urine output can be delayed.
B) Assessing blood pressure is an intervention for all clients brought into the emergency department.
C) The danger of death from a spinal cord injury is greatest when there is damage to, or transection of, the upper cervical region. All people who have sustained trauma to the spine should be treated as though they have a spinal cord injury by stabilizing the neck and spinal cord.
D) An intravenous access line is necessary, but stabilization of the neck and spinal cord is of first priority.
Page Ref: 1014
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 13.G. Analyze spinal cord injury (SCI) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with SCI.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with spinal cord injury.

2) The school nurse is treating a school-age client who has fallen down a flight of stairs. The client is breathing but unconscious. After calling the ambulance, which action should the nurse take?
A) Open the airway using the head tilt maneuver.
B) Try to rouse the client by gently shaking the shoulders.
C) Protect the client's neck and head from any movement.
D) Place the client on the side to prevent aspiration.
Answer: C
Explanation: A) This client is breathing; however, if a change in respirations were to occur, the airway should be opened using the jaw thrust maneuver.
B) Rousing the client by shaking could cause damage to the spinal cord.
C) Guidelines for emergency care are avoiding flexing, extending, or rotating the neck; immobilization of the neck; securing the head; maintaining the client in the supine position; and transferring the client from the stretcher to the hospital bed with backboard in place. This client is unconscious, and the nurse must protect the neck from any (or any further) damage.
D) If the client vomits, the nurse should use the log-roll technique to turn the client while keeping the head, neck, and spine in alignment.
Page Ref: 1014
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

WwW.TeSt.Ws

Learning Outcome: 13.G. Analyze spinal cord injury (SCI) as it relates to mobility. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with SCI.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with spinal cord injury.

3) A client who sustained a cervical neck injury 2 days ago is demonstrating an irregular respiratory pattern with a rate of 8-10 breaths per minute. Based on this data, which problem is the priority?

A) Impaired physical mobility
B) Potential for autonomic dysreflexia
C) Ineffective breathing pattern
D) Impaired gas exchange

Answer: C

Explanation: A) The problem of impaired physical mobility can be addressed later.

B) The client's symptoms are not associated with autonomic dysreflexia.

C) Because the client sustained the neck injury 2 days prior, the full extent of the injuries cannot yet be determined. The client's rate of respirations should be between 12 and 20 breaths per minute. Because the client is breathing irregularly at a rate of 8-10 breaths per minute, the client may need assisted ventilation or a tracheostomy. The priority problem would be ineffective breathing pattern.

D) The problem of impaired gas exchange would be caused by the ineffective breathing pattern.

Page Ref: 1020-1021

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 13.G. Analyze spinal cord injury (SCI) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with SCI.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with spinal cord injury.

4) The nurse is planning care for a client admitted with a high thoracic spinal cord injury. Which interventions would be appropriate for the potential for autonomic dysreflexia? **Select all that apply.**
A) Discuss future care needs when the client is discharged.
B) Increase fluids to 3000 mL per day.
C) Turn and reposition the client every 2 hours.
D) Assess for a full bladder.
E) Assess blood pressure every 2-3 minutes.
Answer: D, E
Explanation: A) Discussing future care needs when discharged is not a priority at this time.
B) There is no evidence to increase the client's fluids to 3000 mL per day.
C) Turning the client every 2 hours is not a priority at this time.
D) Ineffective perfusion can be caused by autonomic dysreflexia, which is an emergency that requires immediate assessment and intervention. Once the client's blood pressure has stabilized or decreased, the nurse can then assess for the stimuli that caused the episode, such as a full bladder.
E) Ineffective perfusion can be caused by autonomic dysreflexia, which is an emergency that requires immediate assessment and intervention. The nurse should continue to assess the client's blood pressure every 2-3 minutes in addition to elevating the head of the bed and removing tight clothing to encourage the pooling of blood in the extremities and decrease the blood pressure.
Page Ref: 1021
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 13.G. Analyze spinal cord injury (SCI) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with SCI.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with spinal cord injury.

5) The nurse is evaluating the effectiveness of interventions to address a client's bowel and bladder dysfunction as a result of a spinal cord injury. Which finding would indicate that these interventions have been successful?
A) The client had two episodes of impacted stool over the last week.
B) The client is improving in ability to perform self-urinary catheterization.
C) The client is limiting fluids to reduce need to void.
D) The client has an indwelling urinary catheter and is provided with stool softeners every morning.
Answer: B
Explanation: A) A client who had two episodes of impacted stool over the last week is not progressing in bowel elimination habits.
B) An ideal outcome for the client with bowel and bladder dysfunction as a result of a spinal cord injury would be for the client to attain appropriate bowel and bladder elimination habits. If the client's ability to perform self-urinary catheterization is improving, the interventions can be considered successful.
C) A client who is limiting fluids to reduce the need to void is possibly hindering his health in order to avoid having to perform self-urinary catheterization.
D) A client with an indwelling urinary catheter who is receiving stool softeners every morning is not progressing toward appropriate bowel and bladder elimination habits.
Page Ref: 1022
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 13.G. Analyze spinal cord injury (SCI) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with SCI.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with spinal cord injury.

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6) The nurse is evaluating the success of a bowel and bladder retraining program with a client who is recovering from a lower motor neuron spinal cord injury. Which observations indicate that this teaching has been successful? **Select all that apply.**

A) One episode of bladder incontinence in 8 hours
B) Client performs self-urinary catheterization every 4 hours while awake
C) Client transfers to use bedside commode after breakfast to evacuate bowels
D) Two episodes of impacted stool in 1 week
E) Client maintains a high-fluid, high-fiber diet

Answer: B, C, E

Explanation: A) Evidence that this training has not been successful includes an episode of bladder incontinence.

B) Evidence that a bowel and bladder retraining program for a client with a spinal cord injury has been successful includes the client performing self-urinary catheterization every 4 hours while awake.

C) Evidence that a bowel and bladder retraining program for a client with a spinal cord injury has been successful includes transferring to the bedside commode to evacuate bowels after breakfast.

D) Evidence that this training has not been successful includes the need to have impacted stool removed twice in 1 week.

E) Evidence that a bowel and bladder retraining program for a client with a spinal cord injury has been successful includes maintaining a high-fluid and high-fiber diet to prevent constipation.

Page Ref: 1021-1022
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation

WwW.TbSu.Ws

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 13.G. Analyze spinal cord injury (SCI) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with SCI.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with spinal cord injury.

7) The nurse is caring for a client who sustained a gunshot wound below the level of T12, resulting in ipsilateral motor paralysis, ipsilateral loss of proprioception and vibratory sense, and contralateral loss of pain and temperature sensation. When planning care for this client, which interpretations of this data by the nurse are likely to be correct? **Select all that apply.**
A) The client's American Spinal Injury Association Impairment Scale score is A.
B) The spinal cord injury is incomplete.
C) These findings are consistent with Brown-Sequard syndrome.
D) Hemisection of the spinal cord is likely.
E) Some recovery of sensory function is likely.
Answer: B, C, D, E
Explanation: A) An American Spinal Injury Association (ASIA) Impairment Scale (AIS) score of A indicates a complete spinal cord injury where no sensory or motor function is preserved in the sacral segments S4-S5.
B) Hemisection of the spinal cord, usually caused by a penetrating trauma (gunshot, knife), causes sensory and motor deficits on opposite sides of the body because the spinal cord injury is incomplete.
C) These findings are consistent with Brown-Sequard syndrome, which has the best prognosis of all the incomplete spinal cord syndromes.
D) Hemisection of the spinal cord, usually caused by a penetrating trauma (gunshot, knife), causes sensory and motor deficits on opposite sides of the body because the spinal cord injury is incomplete.
E) Clients with incomplete SCI will have some return of function.
Page Ref: 1014-1015
Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 13.G. Analyze spinal cord injury (SCI) as it relates to mobility. Identify the clinical manifestations of SCI.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with spinal cord injury.

8) The nurse is presenting a talk on spinal cord injury for a community health fair. Which statement on the part of the attendees indicates that they understand the risk factors and prevention methods associated with spinal cord injury?
A) "There isn't much I can do to prevent a head injury when another vehicle hits my car."
B) "As long as my grandson wears a helmet, he will be safe on his motorcycle."
C) "I'm going to spend extra time discussing this talk with my college-age son because of his higher risk for spinal cord injury."
D) "Due to their elevated risk, I'd like you to present this talk to members of the local Native American population."
Answer: C
Explanation: A) Using a seat belt is a major preventive action for individuals who are involved in motor vehicle crashes.
B) Riding motorcycles increases the risk of spinal cord injuries, even when helmets are used.
C) The highest-risk population for spinal cord injuries is young adult males, including college-age men.
D) Native Americans are the ethnic group with the lowest risk of spinal cord injury.
Page Ref: 1013
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 13.G. Analyze spinal cord injury (SCI) as it relates to mobility. Compare the risk factors for, and prevention of, SCI.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with spinal cord injury.

9) The nurse assesses a young adult client who was involved in a swimming accident that resulted in tetraplegia. The client makes eye contact with the nurse and states, "I'm going to beat this and walk out of here." Based on this statement, which problem should the nurse use to plan this client's care?
A) Potential for mental health problems
B) Impaired physical mobility
C) Inability to perform self-care
D) Potential for autonomic dysreflexia
Answer: A
Explanation: A) The client's statement is unrealistic and could lead to a mental health problem.
B) The client does have tetraplegia and impaired physical mobility; however, the expectation to walk is unrealistic. The issue with impaired physical mobility will be long-term and will need to be addressed over time.
C) The inability to provide self-care would not be the priority.
D) There is no evidence of autonomic dysreflexia.
Page Ref: 1020-1021
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 13.G. Analyze spinal cord injury (SCI) as it relates to mobility. Apply the nursing process in providing culturally competent care to an individual with SCI.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with spinal cord injury.

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10) A female client who sustained a spinal cord injury (SCI) several years ago tells the nurse she is interested in becoming pregnant. She asks the nurse for more information about how her SCI might impact a potential pregnancy. Which statement should the nurse make in response?

A) "Women with SCI should avoid pregnancy, because it puts too much stress on their bodies and can exacerbate their injuries."

B) "If you become pregnant, your risk for autonomic dysreflexia will likely decrease."

C) "The good news is that none of the medications used in the treatment of SCI are known to have detrimental effects on the fetus."

D) "Should you have a baby and opt to breastfeed, you may experience an increase in muscle spasticity."

Answer: D

Explanation: A) Women with SCI are considered to be "high risk" during pregnancy, but that does not mean pregnancy should be avoided.

B) Pregnant women are at higher risk for autonomic dysreflexia, especially during labor and delivery.

C) Many women are unable to continue taking prescribed medications during pregnancy due to the potential harm they pose to the fetus.

D) New mothers must also consider the effects of their SCI on breastfeeding; muscle spasticity may increase during breastfeeding, and women with limited sensation in their breasts may have reduced milk production.

Page Ref: 1020

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 13.G. Analyze spinal cord injury (SCI) as it relates to mobility. Differentiate considerations for care of patients with SCI across the lifespan.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with spinal cord injury.

11) Which client is at highest risk for autonomic dysreflexia?
A) A client with an injury to T9
B) A client with an injury to C7
C) A client with an injury to L2
D) A client with an injury to S1
Answer: B
Explanation: A) Autonomic dysreflexia usually occurs in clients with injuries about T6.
B) Autonomic dysreflexia is the abrupt onset of excessively high blood pressure as the result of an overactive autonomic nervous system; it usually occurs in clients who have injuries above T6.
C) Autonomic dysreflexia usually occurs in clients with injuries above T6.
D) Autonomic dysreflexia usually occurs in injuries above T6.
Page Ref: 1016
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 13.G. Analyze spinal cord injury (SCVI) as it relates to mobility. Identify the clinical manifestations of SCI.
MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with spinal cord injury.

12) In which way should the nurse categorize a client with permanent paralysis of the trunk, arms, and legs?

A) Tetraplegia
B) Paraplegia
C) Spinal shock
D) Complete spinal cord injury (SCI)

Answer: A

Explanation: A) Tetraplegia (also called quadriplegia) is paralysis of the upper and lower limbs and trunk.

B) Paraplegia is paralysis of all or part of the trunk, legs, and pelvic organs.

C) Spinal shock is a temporary condition characterized by spinal cord swelling; decreased blood flow and blood pressure; and complete loss of motor function, spinal reflexes, and autonomic function below the level of injury.

D) Complete SCIs involve a total loss of all sensory and motor function below the level of the injury. Depending on its location, a complete SCI could result in either tetraplegia or paraplegia.

Page Ref: 1015

Cognitive Level: Remembering

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 13.G. Analyze spinal cord injury (SCI) as it relates to mobility. Identify the clinical manifestations of SCI.

MNL LO: Demonstrate understanding of the concept of mobility in the care of a patient with spinal cord injury.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 14 Nutrition

The Concept of Nutrition

1) During a health assessment, a client states, "I only eat carbohydrates and low-fat foods. I don't understand why I am still gaining weight!" Which principles of nutrition should guide the nurse's response? **Select all that apply.**
A) Carbohydrates should only be eaten at breakfast.
B) Eating too many carbohydrates leads to excess glucose, which is converted to fat.
C) Excess carbohydrates can lead to obesity.
D) A carbohydrate-limited diet is the only way to not gain weight.
E) Carbohydrates should be high in fiber and low in sugar.
Answer: B, C, E
Explanation: A) Carbohydrates should be eaten throughout the day.
B) Carbohydrates are converted to glucose; when carbohydrates are consumed in excess, the excess glucose is converted to glycogen, or fat.
C) Carbohydrates are stored in adipose tissue, which can lead to weight gain and an increased risk for obesity.
D) A carbohydrate-limited diet is not the only way to avoid weight gain.
E) Carbohydrates should come from the consumption of foods high in fiber and low in added sugars.
Page Ref: 1030
Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 14.1. Analyze the physiology of nutrition in the body.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

2) The nurse is preparing educational materials for a client with heart failure. Which elements should the nurse include when preparing this material? **Select all that apply.**
A) Advising the client to avoid all sodium in the diet
B) Explaining the effects of sodium on heart function
C) Teaching the client how to read nutritional labels
D) Helping the client to recognize foods that are low in sodium
E) Showing the client how to follow the DASH eating plan
Answer: B, C, D, E
Explanation: A) Sodium is important in the diet, and not all sodium should be avoided.
B) In some people, an increase in sodium intake leads to fluid retention and exacerbates heart failure.
C) The nurse should prepare to teach the client how to read nutritional labels.
D) The nurse should prepare to teach the client how to identify foods that are low in sodium.
E) The nurse should prepare to teach the client about the DASH eating plan.
Page Ref: 1048
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 14.3. Outline the relationship between nutrition and other concepts.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

3) The nurse is performing a nutritional assessment of a client who weighs 185 lbs. and is 5 feet, 3 inches tall. This client's body mass index, rounded to the nearest hundredth, is ________.
Answer: 32.77 BMI
Explanation: The nurse should use the formula [Weight in Pounds/(Height in inches × Height in inches)] × 703 for this calculation. The BMI is calculated by dividing weight in pounds (lb) by height in inches (in) squared and multiplying by a conversion factor of 703. The calculation would be
185 / 63 × 63 = 185 / 3969 = 0.0466112 × 703 = 32.77.
Page Ref: 1042
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 14.3. Differentiate among alterations in nutrition.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

4) The nurse is assessing the nutritional status of an older client. Which finding is most likely to suggest xerostomia?
A) The client refuses food because it is difficult to chew with missing teeth.
B) The client frequently becomes dehydrated due to failure to remember to drink water.
C) The client has a chronically dry mouth despite adequate intake of fluids.
D) The client does not enjoy foods due to diminished taste.
Answer: C
Explanation: A) Xerostomia does not affect chewing of food with missing teeth.
B) Xerostomia is not associated with dehydration although a fluid volume deficit can cause dry mucus membranes.
C) Xerostomia is decreased salivation due to decreased function of salivary glands. The client with a dry mouth most clearly demonstrates xerostomia.
D) A change in the taste of food is unrelated to xerostomia.
Page Ref: 1052
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 14.9. Differentiate considerations related to the care of patients with alterations in nutrition throughout the lifespan.

MNL LO: Analyze the concept of nutrition and its application to nursing care.

5) The nurse is assessing a client who has recently had several blood tests done. Which laboratory results should the nurse identify as indicators of malnutrition? **Select all that apply.**
A) PAB 30 mg/dL
B) PAB 100 mg/L
C) Cholesterol 120 mg/dL
D) Cholesterol 180 mg/dL
E) PAB 12 mg/dL
Answer: B, C, E
Explanation: A) A normal prealbumin (PAB) level is 15-36 mg/dL or 150-360 mg/L. A 30 mg/dL PAB level would not be a cause for concern.
B) A normal prealbumin (PAB) level for adult men and women is 15-36 mg/dL or 150-360 mg/L. A 100 mg/L PAB level would be a cause for concern.
C) A normal cholesterol range is between 160 and 200 mg/ dL. A 120 mg/dL cholesterol level would be a possible indicator of malnutrition.
D) A normal cholesterol range is between 160 and 200 mg/ dL. A 180 mg/dL level would not be cause for concern.
E) A normal prealbumin (PAB) level for adult men and women is 15-36 mg/dL or 150-360 mg/L. A 12 mg/dL PAB level would be a cause for concern.
Page Ref: 1043
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 14.6. Differentiate among common assessment procedures and tests used to evaluate nutritional status.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

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6) The public health nurse is providing community education aimed at promoting nutritional habits that decrease an individual's modifiable risk factors for diseases. Which topics should the nurse include in this teaching session? **Select all that apply.**

A) Benefits of consuming fruits and vegetables

B) Importance of eliminating all fats

C) Selecting lean protein sources

D) Preparing balanced meals

E) Strategies for maintaining recommended daily caloric intake

Answer: A, C, D, E

Explanation: A) Learning about the benefits of consuming fruits and vegetables is a strategy to decrease the risk for disease.

B) Eliminating all fats should not be included, because some fats are considered "healthy" and need to be included in a healthy diet.

C) Learning how to select lean protein sources is a strategy to decrease the risk for disease.

D) Learning how to prepare balanced meals is a strategy to decrease the risk for disease.

E) Learning how to maintain the recommended daily caloric intake is a strategy to decrease the risk for disease.

Page Ref: 1039

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 14.5. Explain the promotion of healthy nutrition.

MNL LO: Analyze the concept of nutrition and its application to nursing care.

7) During a home visit, the nurse is assessing an older adult client. Which assessment findings indicate to the nurse that the client has insufficient nutritional intake? **Select all that apply.**
A) Client reports a problem with dentures slipping while chewing.
B) Client complains of occasional dry mouth and problems with feelings of nausea.
C) Client's adult children arrive to eat dinner together several times a week.
D) Client is prescribed 15 medications.
E) Client's Social Security payments have gone down over the last year.
Answer: A, B, D, E
Explanation: A) The improperly fitting dentures are causing a problem with chewing, which could lead to decreased protein and fruit and vegetable intake.
B) Some medications can cause a dry mouth and nausea.
C) The client's adult children visiting and sharing a meal with the client would likely improve or support the older client's nutritional status.
D) Polypharmacy could negatively influence taste and suppress appetite.
E) Low finances could lead to decreased access to food.
Page Ref: 1052
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 14.9. Differentiate considerations related to the care of patients with alterations in nutrition throughout the lifespan.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

8) The community health nurse reviews data collected during interviews with community members during a health fair for a brochure on improving iron intake. Which information should the nurse include to help vegans and vegetarians increase iron intake? **Select all that apply.**
A) Take calcium supplements.
B) Consume tofu.
C) Consume lentils.
D) Increase intake of vitamin C.
E) Consume Swiss chard.
Answer: B, C, D, E
Explanation: A) Although calcium supplements are good for vegetarians and vegans to take to ensure adequate calcium intake, they do not specifically provide iron.
B) Tofu is a food that both vegans and vegetarians might eat that can provide needed iron.
C) Lentils is a food that both vegans and vegetarians might eat that can provide needed iron.
D) All vegetarians should ensure that they get adequate amounts of iron, and to facilitate the absorption, vitamin C should also be plentiful in the diet.
E) Swiss chard is a food that both vegans and vegetarians might eat that can provide needed iron.
Page Ref: 1028
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 14.7. Analyze independent interventions nurses can implement for patients with alterations in nutrition.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

WwW.TeSm.Ws

9) The nurse is asked to explain bariatric surgery. Which category of clients should the nurse explain that are eligible for this procedure?
A) Overweight
B) Pregnant women
C) Adolescents
D) Morbidly obese
Answer: D
Explanation: A) Bariatric surgery would not be considered for clients who are only overweight.
B) Bariatric surgery would not be considered for clients who are pregnant.
C) Bariatric surgery may be considered in adolescents in severe cases of obesity resistant to previous weight loss attempts, but not simply adolescents as a group regardless of their obesity.
D) For people with morbid obesity, bariatric or lap band surgery is an option.
Page Ref: 1045
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 14.8. Summarize collaborative therapies used by interprofessional teams for patients with alterations in nutrition.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

10) The nurse is reviewing the role of vitamins in maintaining health. Which statement best characterizes vitamin use?
A) Vitamins except for D and K must be consumed through dietary intake.
B) Excess vitamin C can cause nausea, vomiting, weakness, and kidney failure.
C) Generally, two multivitamin pills a day is recommended for all clients regardless of diet.
D) Fat-soluble vitamins in general present the least risk of toxicity to clients who take them in excess.
Answer: A
Explanation: A) With the exception of vitamins D and K, they must be consumed as a part of dietary intake. Vitamin D is manufactured by ultraviolet irradiation of cholesterol molecules in the skin, and vitamin K is synthesized by bacteria in the intestine.
B) Excess vitamin D can cause nausea, vomiting, weakness, and kidney failure.
C) Two multivitamin pills a day is probably excessive because one such vitamin typically contains the recommended intakes of most vitamins and minerals needed on a daily basis and determinations of vitamin intake should always consider diet.
D) Excess consumption of some vitamins, especially the fat-soluble vitamins, can lead to significant toxicity.
Page Ref: 1031, 1038
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 14.8. Summarize collaborative therapies used by interprofessional teams for patients with alterations in nutrition.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

Exemplar 14.A Obesity

1) An adolescent of normal weight reports periods of overeating, especially when parents fight. Which factor increases this client's risk for obesity?
A) Cultural and environmental factors
B) Heredity
C) Low socioeconomic status
D) Physical inactivity
Answer: A
Explanation: A) This client most often overeats because of stress, which is an environmental risk factor for obesity. The client's stress comes from the environment, such as problems at school or at home.
B) The client's overeating is not caused by genetics because the client is of normal weight. Specific genes are associated with obesity of which the client is not demonstrating or experiencing.
C) The client's stress does not come from low socioeconomic status.
D) The client's stress does not come from physical inactivity.
Page Ref: 1056
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 14.A. Analyze obesity as it relates to nutrition. Compare the risk factors and prevention of obesity.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

2) A female client has a BMI of 33.2 and waist circumference 90 cm. In which way should the nurse classify this client's obesity?
A) Overweight
B) Obese Class 1
C) Obese Class 2
D) Obese Class 3
Answer: B
Explanation: A) A BMI between 25.0 to 29.9 is considered overweight.
B) A BMI of 33.2 would be in the range for Class I obesity (30.0-34.9). The waist circumference of 90 cm for a woman increases the risk for disease.
C) A BMI between 35.0 and 39.9 is classified as Obesity Class 2.
D) A BMI over 40.0 is classified as Obesity Class 3.
Page Ref: 1057
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 14.A. Analyze obesity as it relates to nutrition. Identify the clinical manifestations of obesity.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

3) The nurse is planning a teaching seminar for a group of young adult clients who are at risk for obesity. Which statement by the nurse best addresses their needs?
A) There are drugs that are good to use to reduce weight.
B) Obesity often leads to low self-esteem and depression.
C) Proper diet and exercise programs can not only prevent obesity but also potentially improve the ability to think and the positivity of self-perception.
D) Maternal obesity often leads to menstrual irregularities and higher incidences of infertility.
Answer: C
Explanation: A) Drugs are used to manage obesity, not prevent it.
B) Although obesity is a risk factor for low self-esteem and depression, emphasizing these negative effects does not empower clients to address their risk factors.
C) The young adults who are at risk for obesity need education about changing lifestyles and the importance of preventing obesity as opposed to treating it. Education should include tips on eating healthy and exercising, which can lead to other benefits besides preventing obesity.
D) Information about maternal obesity is not necessarily relevant to all individuals and does not address health promotion.
Page Ref: 1059
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 14.A. Analyze obesity as it relates to nutrition. Differentiate care of patients with obesity across the lifespan.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

4) The nurse is caring for a morbidly obese client who is seeking help to lose weight at a bariatric clinic. When planning this client's care, which problem is the priority?

A) Inability to tolerate activity
B) Imbalanced oral intake
C) Issues with coping
D) Changes in body processes

Answer: A

Explanation: A) Along with diet, exercise is an important part of a weight loss program. A client with morbid obesity has a sedentary lifestyle and will have activity intolerance.

B) An imbalance in oral intake might be a contributing factor to the obesity; however, this is not the priority problem.

C) There is no evidence that the client has a problem with coping.

D) There is no evidence that the client has changes in body processes.

Page Ref: 1062

Cognitive Level: Analyzing

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 14.A. Analyze obesity as it relates to nutrition. Apply the nursing process for providing culturally competent care to an individual with obesity.

MNL LO: Analyze the concept of nutrition and its application to nursing care.

5) The nurse is caring for an adult client with a BMI of 26.8 who complains of sleep apnea and gout. Which therapies will the nurse anticipate for this client? **Select all that apply.**

A) Pharmacotherapy

B) Diet

C) Exercise

D) Behavior modification

E) Surgery

Answer: B, C, D

Explanation: A) Pharmacotherapy is not indicated for the client with this BMI.

B) Clients with a BMI of 25-26.9 with two or more comorbidities–sleep apnea and gout in this case–would be treated with diet.

C) Clients with a BMI of 25-26.9 with two or more comorbidities–sleep apnea and gout in this case–would be treated with exercise.

D) Clients with a BMI of 25-26.9 with two or more comorbidities–sleep apnea and gout in this case–would be treated with behavior modification.

E) Surgery is not indicated for a client with this BMI.

Page Ref: 1058

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 14.A. Analyze obesity as it relates to nutrition. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with obesity.

MNL LO: Analyze the concept of nutrition and its application to nursing care.

6) The nurse is teaching a client scheduled for Roux-en-Y gastric bypass surgery about potential postsurgical complications and how to reduce them. Which client statement best indicates that teaching has been effective?
A) "I need to eat at least one meal a day that is high in simple carbohydrates."
B) "Complications of this surgery are likely to be limited to mild gastrointestinal issues for several days."
C) "I need to be alert for the indications of vitamin deficiencies."
D) "I will not continue my exercise program following this surgery."
Answer: C
Explanation: A) Eating meals high in simple carbohydrates can bring on dumping syndrome, a complication in which stomach contents move rapidly through the small intestine, drawing fluid into the intestine by osmosis.
B) Mild GI issues are not the only significant complication of this surgery.
C) Because these procedures allow food to bypass the duodenum and jejunum, nutrient deficiencies, particularly of iron, calcium, vitamin B_{12}, and, possibly, the fat-soluble vitamins, are common.
D) The client likely should continue the exercise program.
Page Ref: 1060
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 14.A. Analyze obesity as it relates to nutrition. Compare the risk factors and prevention of obesity.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

7) The nurse is providing teaching to a female client about dietary modifications to promote weight loss. Which statement by the nurse is accurate?
A) "You will need to follow a lower calorie diet until you lose the weight you want.”
B) "Intermittent fasting is the best approach to follow.”
C) "All fats should be eliminated from the diet.”
D) "We need to decide the best diet approach to meet your weight loss goals.”
Answer: D
Explanation: A) Sustaining weight loss requires individuals to incorporate new patterns in their lives and this requires education and support.
B) Intermittent fasting is not a recommended eating approach to lose weight.
C) No single food group should be eliminated from the diet.
D) For food intake, diets that decrease calorie intake in general, such as a low-calorie, very-low-calorie, meal-replacement, low-carbohydrate, high-protein, ketogenic, or Mediterranean diet can be implemented.
Page Ref: 1060
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 14.A. Analyze obesity as it relates to nutrition. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with obesity.

MNL LO: Analyze the concept of nutrition and its application to nursing care.

8) The nurse is caring for a school-age client who wants to lose weight. Which suggestion by the nurse might assist the client in being compliant with the weight loss plan in a way that is sensitive to the client's age?
A) "It can be difficult to avoid unhealthy foods if that's what your friends are eating but try to choose healthier options when you can."
B) "Write down the exact foods you eat so that you can see what and how much you are eating."
C) "Watch the nutrient content and number of calories in everything you eat."
D) "Eat at the kitchen table so that you eat along with the rest of the family."
Answer: A
Explanation: A) Nurses in the community, especially in local school systems, are well placed to provide education to children and their families about appropriate food choices and the factors that lead to childhood obesity.
B) Keeping food diaries and monitoring the nutrient content and caloric values of food intake are helpful behavior modification strategies, but these don't take into account the age of the client.
C) Studies on food consumption show that caloric information or nutrient content is not a major consideration in choice among clients.
D) Parental food choices can have a strong impact on children, but some children rebel against these food choices, positively or negatively, and eating with the rest of the family is only beneficial if the family's habits are healthy.
Page Ref: 1061
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 14.A. Analyze obesity as it relates to nutrition. Differentiate considerations for care of patients with obesity across the lifespan.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

9) The nurse is planning care for a client with morbid obesity. Which action will the nurse take to support this client's weight loss?
A) Help identify strategies for stress eating
B) Discuss self-monitoring with calorie counts
C) Plan a program of regular increasing activity
D) Establish weight loss goals of 1 to 2 lbs./week
Answer: A
Explanation: A) To promote weight loss, the client should identify strategies for stress eating.
B) Self-monitoring with calorie counts supports education to promote good health maintenance.
C) A program of regular increasing activity supports the problem of encouraging exercise.
D) Establishing a weight loss goal of 1 to 2 lbs./week supports education to promote good health maintenance.
Page Ref: 1063
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 14.A. Analyze obesity as it relates to nutrition. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with obesity.

MNL LO: Analyze the concept of nutrition and its application to nursing care.

10) The nurse is creating a teaching tool about weight loss and obesity. Which statements regarding upper body obesity should be included? **Select all that apply.**
A) Upper body obesity is also called peripheral obesity.
B) Upper body obesity is the condition in which the waist-to-hip ratio in men is greater than 0.8 or greater than 1 in women.
C) Upper body obesity is associated with a greater risk of cardiovascular mortality.
D) Normal-weight obesity is not harmful to health.
E) Women with upper body obesity are at risk for gestational diabetes.
Answer: C, E
Explanation: A) Upper body obesity is also called central obesity.
B) Upper body obesity is defined as having waist circumference measurements greater than 102 cm (40 in.) for males and 89 cm (35 in.) for females.
C) Researchers found individuals with central obesity when compared to normal-weight individuals to be at greater risk for cardiovascular mortality.
D) Another aspect of central obesity is normal-weight obesity in which individuals are centrally obese but have a normal BMI. The weight-to-height ratio is greater than normal, and reduction of this ratio is the goal rather than weight loss alone.
E) Researchers found individuals with central obesity when compared to normal-weight individuals to be at greater risk for general and gestational diabetes.
Page Ref: 1057
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 14.A. Analyze obesity as it relates to nutrition. Identify the clinical manifestations of obesity.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

11) The nurse is asked to explain basal metabolic rate. Which information will the nurse include in response?
A) The amount of energy stored in fat each day
B) The speed of triglyceride breakdown
C) The cost in kilocalories of being alive
D) The speed at which glucose is converted to energy
Answer: C
Explanation: A) BMR is not the amount of energy stored in fat each day.
B) BMR is not the speed of triglyceride breakdown.
C) BMR is the "cost" (in kilocalories) of being alive.
D) BMR is not the speed at which glucose is converted to energy.
Page Ref: 1055
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 14.A. Analyze obesity as it relates to nutrition. Describe the pathophysiology of obesity.
MNL LO: Analyze the concept of nutrition and its application to nursing care.

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Module 15 Oxygenation

The Concept of Oxygenation

1) The nurse recognizes that which pathophysiologic changes are occurring when caring for the client with respiratory acidosis? **Select all that apply.**
A) Increased CO_2
B) Vasoconstriction
C) Decreased O_2
D) Decreased intracranial pressure (ICP)
E) Increased pulse rate
Answer: A, C, E
Explanation: A) Respiratory acidosis is an alteration of acid-base imbalance that results in an excess of dissolved carbon dioxide (increased CO_2).
B) Vasodilatation, not vasoconstriction, occurs as a low pH results in relaxation of vascular smooth muscle by interrupting the normal function of calcium channels.
C) Respiratory acidosis is an alteration of acid-base imbalance that is caused by decreased oxygen intake.
D) Cerebral vasodilation results in increased intracranial pressure.
E) The pulse rate increases in an attempt to compensate for oxygen deprivation.
Page Ref: 1075
Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.3. Outline the relationship between oxygenation and other concepts.
MNL LO: Analyze the concept of oxygenation and its application to nursing care.

2) The nurse is providing care to a client diagnosed with chronic obstructive pulmonary disease (COPD). Which clinical manifestations are the direct result of altered perfusion? **Select all that apply.**

A) Bounding pulse
B) Pink nail beds
C) Cyanosis
D) Confusion
E) Wheezing

Answer: C, D

Explanation: A) A weak pulse indicates poor perfusion.
B) Blue nail beds indicate poor perfusion.
C) Clinical manifestations associated with a decrease in perfusion include cyanosis.
D) Clinical manifestations associated with a decrease in perfusion include confusion.
E) Wheezing is an abnormal breath sound that is the result of excess mucus in the airways.

Page Ref: 1073
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.3. Outline the relationship between oxygenation and other concepts.
MNL LO: Analyze the concept of oxygenation and its application to nursing care.

3) The nurse is providing care to an adult client with a long history of chronic obstructive pulmonary disease (COPD). The client is admitted to the intensive care unit with a pneumothorax. Which interventions are appropriate for this client? **Select all that apply.**
A) Elevate head of the bed
B) Administer a high rate of oxygen by nasal cannula
C) Prepare for a chest tube insertion
D) Administer prescribed antihypertensive medications
E) Administer intravenous caffeine per order
Answer: A, C
Explanation: A) The nurse providing care to a client with COPD and a pneumothorax would elevate the head of the bed because of the client's dyspnea and orthopnea.
B) Because clients with COPD have a decreased response to hypercarbia, which stimulates breathing, a high rate of oxygen by nasal cannula is inappropriate.
C) The nurse providing care to a client with COPD and a pneumothorax would prepare for a chest tube insertion.
D) There is no indication that the client is experiencing hypertension.
E) IV caffeine is administered to premature infants as a respiratory stimulant. This intervention is not appropriate for an adult client diagnosed with COPD and a pneumothorax.
Page Ref: 1074
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.2. Differentiate among alterations in oxygenation.
MNL LO: Analyze the concept of oxygenation and its application to nursing care.

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4) When auscultating the lungs of a client experiencing dyspnea, the nurse hears a low-pitched sound that is continuous throughout inspiration. Which condition caused this lung sound?
A) Narrow bronchi
B) Narrow trachea passages
C) Blocked large airway passages
D) Inflamed pleural surfaces
Answer: C
Explanation: A) Wheezing is created by narrow bronchi.
B) Stridor is the sound created by narrow tracheal passages.
C) Rhonchi suggests blockage of large airway passages, which may be cleared with coughing.
D) A low-pitched grating sound is created by inflamed pleural surfaces.
Page Ref: 1078
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.5. Differentiate among common assessment procedures and tests used to examine oxygenation.
MNL LO: Analyze the concept of oxygenation and its application to nursing care.

5) The nurse is reviewing the results of laboratory tests conducted on a client admitted with an alteration in respiratory function. Which laboratory finding would be most significant for this client?
A) Hemoglobin level 14 g/dL
B) Oxygen saturation 96%
C) Serum sodium 140 mg/dL
D) Blood pH 7.32
Answer: D
Explanation: A) The hemoglobin level affects the amount of oxygen that can be carried in the blood; however, the value is within normal limits.
B) Oxygen saturation of 96% is within normal limits.
C) The serum sodium does not impact the oxygen capacity of the body.
D) Normal blood pH is 7.35-7.45. A decreased pH indicates that the client is experiencing acidosis, which indicates an alteration in oxygenation.
Page Ref: 1081
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.5. Differentiate among common assessment procedures and tests used to examine oxygenation.
MNL LO: Analyze the concept of oxygenation and its application to nursing care.

6) A client with chronic obstructive pulmonary disease (COPD) is prescribed oxygen 24% 2 L/min. Which is the best method to administer oxygen to this client?
A) Face mask
B) Nasal cannula
C) Nonrebreather mask
D) Venturi mask
Answer: B
Explanation: A) A face mask is suited for higher percentages of oxygen and higher flow rates.
B) The oxygen delivery device that would safely administer 24% oxygen at the flow rate of 2 liters per minute is through nasal cannula.
C) A nonrebreather mask is suited for higher percentages of oxygen and higher flow rates.
D) A Venturi mask is suited for higher percentages of oxygen and higher flow rates.
Page Ref: 1088
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 15.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in oxygenation.
MNL LO: Analyze the concept of oxygenation and its application to nursing care.

7) The nurse is planning care for a client experiencing dyspnea and a subsequent activity intolerance. Which action by the nurse is the most appropriate?
A) Encourage strenuous activity.
B) Consult a dietitian for low-calorie meals.
C) Space periods of activity with periods of rest.
D) Encourage dependence with activities of daily living.
Answer: C
Explanation: A) The client will be weak, so the nurse should not encourage strenuous activity.
B) Clients with respiratory disorders often need an increase, not a decrease, in calories to maintain body functions.
C) The client with shortness of breath will experience activity intolerance due to a lack of oxygen and fatigue. It will often be appropriate to space periods of activity with periods of rest.
D) The nurse would want the client to be as independent as possible and would not encourage dependence with activities of daily living.
Page Ref: 1084
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 15.6. Analyze independent interventions nurses can implement for patients with alterations in oxygenation.
MNL LO: Analyze the concept of oxygenation and its application to nursing care.

8) The nurse is providing care for a client admitted during an acute exacerbation of asthma. Which medication does the nurse anticipate to relieve the acute symptoms exhibited by the client?
A) Inhaled short-acting beta-agonists
B) Oral corticosteroids
C) Inhaled long-acting beta-agonists
D) Oral anticholinergics
Answer: A
Explanation: A) The client admitted with an acute exacerbation of asthma will require a rescue medication, such as an inhaled short-acting beta-agonist.
B) Oral corticosteroids are maintenance medications used to treat asthma.
C) Inhaled long-acting beta agonists are maintenance medications used to treat asthma.
D) Oral anticholinergics are maintenance medications used to treat asthma.
Page Ref: 1086
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 15.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in oxygenation.

MNL LO: Analyze the concept of oxygenation and its application to nursing care.

9) The nurse assigned to the newborn nursery is conducting shift assessments. While assessing one newborn, the nurse notes the respiratory rate is 52 breaths per minute. Which action by the nurse is appropriate?

A) Notify the healthcare provider of this assessment finding.
B) Obtain an arterial blood gas for further respiratory assessment.
C) Begin monitoring the respiratory rate every 5 minutes.
D) Continue to monitor the newborn per facility policy.

Answer: D

Explanation: A) The healthcare provider does not need to be notified.
B) An arterial blood gas is not needed.
C) There is no need to monitor the respiratory rate every 5 minutes.
D) A respiratory rate of 52 breaths per minute is a normal finding in a newborn. Respiratory rates are highest and most variable in newborns. The respiratory rate of a neonate or newborn is 30-80 breaths per minute. Therefore, this client only needs monitoring.

Page Ref: 1071

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 15.8. Differentiate considerations related to the care of patients with alterations in oxygenation throughout the lifespan.

MNL LO: Analyze the concept of oxygenation and its application to nursing care.

10) The nurse is conducting an assessment for a client on a medical-surgical unit. Which findings are indicative of a client who is experiencing tachypnea? **Select all that apply.**
A) Excessive rapid breathing
B) Chest pain
C) Rapid breathing at rest
D) Shallow breathing
E) Cyanosis
Answer: A, C, D
Explanation: A) Excessive rapid breathing is a manifestation of tachypnea.
B) Chest pain is a manifestation of a pneumothorax.
C) Rapid breathing at rest is a manifestation of tachypnea.
D) Shallow breathing is a manifestation of tachypnea.
E) Cyanosis is a late manifestation of hypoxemia.
Page Ref: 1072
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.2. Differentiate among alterations in oxygenation.
MNL LO: Analyze the concept of oxygenation and its application to nursing care.

11) The charge nurse is observing a newly licensed nurse conduct an admission assessment on a client with asthma. Which action by the newly licensed nurse requires immediate intervention?
A) The newly licensed nurse is observed obtaining the pulse oximetry reading 10 minutes after the client used an albuterol inhaler.
B) The newly licensed nurse is observed continuing to ask the client questions regarding history while the client demonstrates difficulty breathing and signs of respiratory impairment.
C) The newly licensed nurse is observed assessing the client's thoracic wall, skin, and nail beds.
D) The newly licensed nurse is observed auscultating breath sounds with a stethoscope.
Answer: B
Explanation: A) Although the pulse oximetry reading may not be a true indicator of the level of respiratory distress of the client because of the use of an albuterol inhaler within 30-60 minutes of this assessment, it is still an appropriate action for the newly licensed nurse to take and does not require the charge nurse to intervene immediately.
B) The charge nurse should intervene immediately if the nurse observes the client is demonstrating impairment at or near respiratory failure; the client will not be able to respond to questions. Assessment questions should be tailored and asked of any family member or friend accompanying the client.
C) Assessing the client's thoracic wall, skin, and nail beds is an appropriate action at this time.
D) Auscultating the client's breath sounds with the use of a stethoscope is appropriate.
Page Ref: 1075
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 15.5. Differentiate among common assessment procedures and tests used to examine oxygenation.
MNL LO: Analyze the concept of oxygenation and its application to nursing care.

12) Which independent nursing interventions are appropriate for a client who is experiencing an alteration in oxygenation? **Select all that apply.**
A) Encouraging deep breathing exercises
B) Assisting with positioning
C) Providing suctioning
D) Prescribing bronchodilators
E) Monitoring activity intolerance
Answer: A, B, C, E
Explanation: A) Examples of independent interventions that nurses can provide to clients with alterations in oxygenation include deep breathing exercises.
B) Examples of independent interventions that nurses can provide to clients with alterations in oxygenation include assisting with positioning.
C) Examples of independent interventions that nurses can provide to clients with alterations in oxygenation include suctioning.
D) It is outside the scope of nursing practice to prescribe a bronchodilator to a client. The nurse, however, can administer a prescribed bronchodilator. This is considered a collaborative nursing intervention.
E) Examples of independent interventions that nurses can provide to clients with alterations in oxygenation include monitoring activity intolerance.
Page Ref: 1083-1085
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.6. Analyze independent interventions nurses can implement for patients with alterations in oxygenation.
MNL LO: Analyze the concept of oxygenation and its application to nursing care.

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13) While performing nasotracheal suctioning, the nurse notes the older adult client with an alteration in oxygenation is moving the head around and pulling at the nurse's hand to remove the suction catheter. Which actions by the nurse are appropriate? **Select all that apply.**
A) Remove the suction catheter
B) Lower the head of the bed
C) Decrease the suction pressure
D) Apply restraints to the client's arms and legs
E) Hyperoxygenate the client
Answer: A, C, E
Explanation: A) The older adult client is demonstrating signs of hypoxemia. The nurse should remove the suction catheter.
B) The older client is demonstrating signs of hypoxemia. The client should be in the Fowler or high-Fowler position.
C) The older client is demonstrating signs of hypoxemia. The nurse should decrease the suction pressure.
D) Restraining the patient does not address the hypoxemia.
E) The older client is demonstrating signs of hypoxemia. The nurse should hyperoxygenate the client.
Page Ref: 1092-1093
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 15.8. Differentiate considerations related to the care of patients with alterations in oxygenation throughout the lifespan.
MNL LO: Analyze the concept of oxygenation and its application to nursing care.

14) Which structure in the respiratory system is the site of gas exchange?
A) Macrophage
B) Bronchi
C) Alveoli
D) Bronchiole
Answer: C
Explanation: A) Macrophages are immune cells that keep the alveoli region free of microbes.
B) The bronchi are larger structures in the respiratory system that serve as tracts for airflow.
C) The alveoli comprise the terminal structures of the lower respiratory system. Alveoli serve as the sites of gas exchange, specifically, carbon dioxide and oxygen.
D) Bronchioles are larger structures in the respiratory system that serve as tracts for airflow.
Page Ref: 1070
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate the knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.1. Analyze the physiology of oxygenation in the body.
MNL LO: Analyze the concept of oxygenation and its application to nursing care.

15) In which way do vaccinations promote healthy oxygenation?
A) Reduce the transmission of preventable diseases
B) Increase the exchange of oxygen for carbon dioxide in the lungs
C) Promote adequate blood circulation to organs and tissues
D) Prevent all respiratory infections
Answer: A
Explanation: A) Vaccinations help decrease the transmission of preventable diseases, many of which are spread by respiratory secretions. Many of these diseases also affect the respiratory system and can alter oxygenation.
B) Vaccinations do not directly increase the exchange of oxygen for carbon dioxide in the lungs.
C) Vaccinations do not promote adequate blood circulation.
D) Vaccinations can prevent some respiratory infections, but not all respiratory infections, and they can also prevent some non-respiratory infections.
Page Ref: 1076
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.4. Explain the promotion of healthy oxygenation.
MNL LO: Analyze the concept of oxygenation and its application to nursing care.

Exemplar 15.A Acute Respiratory Distress Syndrome

1) Which clinical manifestation does the nurse correctly attribute to hypoxia in a client with acute respiratory distress syndrome (ARDS)?
A) Fluid imbalance
B) Hypertension
C) Bradycardia
D) Dyspnea
Answer: D
Explanation: A) Fluid and electrolyte imbalances occur due to the nutritional imbalances associated with ARDS.
B) Dyspnea does not cause hypertension in the client with hypoxia secondary to ARDS. Fluid and electrolyte imbalances occur due to the nutritional imbalances associated with ARDS. The nurse would expect tachycardia, not bradycardia, as a result of hypoxia.
C) The nurse would expect tachycardia, not bradycardia, as a result of hypoxia.
D) Dyspnea is a clinical manifestation of clients experiencing hypoxia secondary to ARDS.
Page Ref: 1095
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Identify the clinical manifestations of ARDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

2) The nurse is providing care to a client admitted to the emergency department with the diagnosis of acute respiratory distress syndrome (ARDS). When educating the client's family, in which order should the nurse instruct as the expected progression of the disease process?
A) Initiation of ARDS
B) Onset of pulmonary edema
C) End-stage ARDS
D) Alveolar collapse
Answer: A, B, D, C
Explanation: ARDS begins with inflammatory cellular responses and biochemical mediators that damage the alveolar-capillary membrane. Increased interstitial pressure and damage to the alveolar membrane allow fluid to enter the alveoli. The inflammatory process damages surfactant-producing cells, leading to a deficit of surfactant, increased alveolar surface tension, and alveolar collapse. Multiple-organ system dysfunction of the kidneys, liver, gastrointestinal tract, central nervous system, and cardiovascular system are the leading causes of death in ARDS.
Page Ref: 1094
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | | Nursing Process: Implementation
Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Describe the pathophysiology of ARDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

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3) The nurse is providing care to a client with sepsis due to a severely infected leg wound. The client states that he is having trouble breathing. Upon assessment, the nurse notes dyspnea, a respiratory rate of 32, the use of accessory muscles to breathe, and rales and rhonchi upon auscultation of the lungs. The nurse recognizes these findings as characteristic of which condition?
A) Allergic response from antibiotic therapy
B) Deep vein thrombosis
C) Acute respiratory distress syndrome
D) Anemia
Answer: C
Explanation: A) An allergic response from antibiotic therapy may or may not be associated with a systemic infection from an infected leg wound and is not associated with the development of ARDS.
B) Deep vein thrombosis may or may not be associated with a systemic infection from an infected leg wound and is not associated with the development of ARDS.
C) Sepsis is one of the most common causes of acute respiratory distress syndrome (ARDS). The client has a systemic infection, which is sepsis, and is complaining that it is getting hard to breathe. Pulmonary assessment data indicate that the client is developing acute respiratory distress.
D) Anemia may or may not be associated with a systemic infection from an infected leg wound and is not associated with the development of ARDS.
Page Ref: 1094
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Identify the clinical manifestations of ARDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

4) A client with a respiratory rate of 8 breaths per minute has an oxygen saturation of 82%. Which problem is a priority for this client?

A) Risk for infection

B) Inadequate spontaneous ventilation

C) Potential for confusion

D) Decreased cardiac output

Answer: B

Explanation: A) Risk for infection is not a priority problem for this client.

B) A priority problem for a client with a respiratory rate of 8 breaths per minutes and an oxygen saturation of 82% is inadequate spontaneous ventilation. If the current pattern continues without intervention, the client could experience respiratory arrest.

C) The potential for confusion is not a current problem for this client.

D) Decreased cardiac output is not a current problem for this client.

Page Ref: 1103

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with ARDS.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

5) A client with acute respiratory distress syndrome (ARDS) is being weaned from ventilatory support. Which nursing actions are appropriate for this client? **Select all that apply.**
A) Increase percentage of oxygen being provided through the ventilator.
B) Place in the Fowler position.
C) Provide morning care during the weaning procedures.
D) Begin weaning procedures in the morning.
E) Medicate with morphine for pain as needed.
Answer: B, D
Explanation: A) The percentage of oxygen is typically reduced during the weaning process.
B) The client should be in the Fowler or high-Fowler position, as this facilitates lung expansion and reduces the work of breathing.
C) Activities and care should be limited during the weaning process to reduce the demand for oxygen.
D) Weaning a client from ventilatory support should begin in the morning when the client is well-rested.
E) The client should not be given any medication known to suppress respirations, as this would interfere with the weaning process.
Page Ref: 1105
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with ARDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

6) A client receiving treatment for acute respiratory distress syndrome (ARDS) is demonstrating anxiety related to having to stay on the ventilator indefinitely. Which interventions by the nurse are appropriate? **Select all that apply.**

A) Explain about care areas specifically designed for long-term ventilatory support.
B) Dim the lights and reduce distracting noise, such as the television.
C) Instruct that intubation and ventilation are temporary measures.
D) Encourage family visits and participation in care.
E) Remain with the client as much as possible.

Answer: C, D, E

Explanation: A) Explaining that there are care areas designed for long-term ventilatory support could increase the client's anxiety.

B) The nurse should provide distractions such as television or radio and not dim the lights or turn off the television, which could also increase the client's anxiety.

C) The nurse should instruct that intubation and ventilation are temporary measures to allow the lungs to rest and heal.

D) A critical illness creates anxiety for any client. For the client with ARDS, anxiety is compounded by intubation and mechanical ventilation. To reduce this client's anxiety, the nurse should encourage the family to visit and participate in care.

E) A critical illness creates anxiety for any client. For the client with ARDS, anxiety is compounded by intubation and mechanical ventilation. To reduce this client's anxiety, the nurse should remain with the client as much as possible.

Page Ref: 1105
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation

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Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with ARDS.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

7) Which data supports the nurse's assessment that a newborn with acute respiratory distress syndrome (ARDS) is improving?
A) Increased $PaCO_2$
B) Oxygen saturation of 92%
C) Pulmonary vascular resistance increases
D) Thick secretions from the respiratory tract
Answer: B
Explanation: A) Increased $PaCO_2$ indicates continued distress.
B) An expected outcome for a client being treated for ARDS is maintaining an oxygen saturation of greater than 90%. The newborn diagnosed with ARDS with an oxygen saturation of 92% is improving.
C) Increased pulmonary vascular resistance indicates continued distress.
D) Thick secretions from the respiratory tract indicates continued distress.
Page Ref: 1098
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Differentiate care of patients with ARDS across the lifespan.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

8) The nurse educator prepares to speak to a group of nursing students about direct and indirect insults to the lungs that may lead to the development of acute respiratory distress syndrome (ARDS). Which conditions will the nurse include in the teaching session? **Select all that apply.**
A) Sepsis
B) Viral pneumonia
C) Drug overdose
D) Near drowning in saltwater
E) Fractured humerus
Answer: A, B, C, D
Explanation: A) ARDS is a severe form of acute respiratory failure that occurs in response to pulmonary or systemic insults. Such insults include sepsis.
B) ARDS is a severe form of acute respiratory failure that occurs in response to pulmonary or systemic insults. Such insults include pulmonary infections.
C) ARDS is a severe form of acute respiratory failure that occurs in response to pulmonary or systemic insults. Such insults include drug overdose.
D) ARDS is a severe form of acute respiratory failure that occurs in response to pulmonary or systemic insults. Such insults include saltwater inhalation.
E) A fractured humerus is not a risk factor for the development of ARDS.
Page Ref: 1094
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

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Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Summarize risk factors for ARDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

9) The nurse is caring for a client admitted with septic shock. Which early clinical manifestation might indicate the development of ARDS?
A) Intercostal retractions
B) Cyanosis
C) Tachypnea
D) Tachycardia
Answer: C
Explanation: A) As the distress progresses, the client would demonstrate intercostal retractions.
B) Cyanosis is a late manifestation.
C) Dyspnea and tachypnea are early clinical manifestations of ARDS.
D) As the distress progresses, the client would demonstrate tachycardia.
Page Ref: 1095
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Identify the clinical manifestations of ARDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

10) A client admitted with smoke inhalation injuries develops signs and symptoms of acute respiratory distress syndrome (ARDS). The nurse anticipates the healthcare provider will prescribe which course of action with regard to oxygenation?
A) Oxygen via a nasal cannula
B) Mechanical ventilation
C) Oxygen via a face mask
D) Oxygen via a Venturi mask
Answer: B
Explanation: A) Oxygen administered via nasal cannula requires active and adequate breathing by the client, which may not be possible for the client with ARDS.
B) With ARDS, it is rarely possible to maintain adequate tissue oxygenation with oxygen therapy alone. Therefore, mechanical ventilation is often necessary.
C) Oxygen administered via face mask requires active and adequate breathing by the client, which may not be possible for the client with ARDS.
D) Oxygen administered via Venturi mask requires active and adequate breathing by the client, which may not be possible for the client with ARDS.
Page Ref: 1097
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with ARDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

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11) The nurse is caring for a client diagnosed with acute respiratory distress syndrome (ARDS). The client is intubated and placed on mechanical ventilation with positive pressure ventilation. Which assessment finding indicates a decrease of cardiac output secondary to positive pressure ventilation?

A) Blood pressure increases from 88/58 mmHg to 90/60 mmHg
B) Urine output decreases from 30 mL/hr to 25 mL/hr
C) Heart rate drops from 108 bpm to 104 bpm
D) Oxygen saturation increases from 82% to 90%

Answer: B

Explanation: A) Although hypotension indicates a decreased cardiac output, the level is improved from the previous assessment, suggesting it is not contributing to decreased cardiac output.

B) Reduced cardiac output results in reduced perfusion of the kidneys, with a resulting decrease in urine output. Expected urine output is at least 30 mL/hr. This client's urine output is decreased; therefore, this finding supports the problem of decreased cardiac output.

C) Although tachycardia is an indication of a decreased cardiac output, the rate has improved from the previous assessment, suggesting that it is not contributing to decreased cardiac output.

D) The oxygen saturation level is within normal limits for this client and improving from the previous assessment.

Page Ref: 1104

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with ARDS.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

12) The nurse is providing care to a client with ARDS who has a tracheostomy. The nurse will monitor the client for complications related to the loss of which protective mechanism?
A) The ability to cough
B) Filtration and humidification of inspired air
C) Decrease in oxygen-carrying capacity of the trachea
D) The sneeze reflex initiated by irritants in the nasal passages
Answer: B
Explanation: A) The client can still cough.
B) When the nasal passages are bypassed, as they would be in the case of a client with a tracheostomy, the filtration, humidification, and warming provided by the nasal passages are also bypassed.
C) There is no decrease in the oxygen-carrying capacity of the trachea.
D) The client can still sneeze.
Page Ref: 1101
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with ARDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

13) Which client will the nurse identify as likely to have the poorest outcome from ARDS?
A) Hispanic male with pneumonia
B) African American male with sepsis
C) White female with sepsis
D) African American female with chest trauma
Answer: B
Explanation: A) The risk for mortality from ARDS is not greater in Hispanic clients.
B) The risk for mortality from ARDS is greater for men than for women, and it is greater for African Americans than people from other races. In addition, clients who develop ARDS from sepsis have poorer outcomes than clients who develop ARDS from pulmonary infections or trauma. Therefore, the African American male with ARDS from sepsis will likely have the poorest outcome.
C) The risk for mortality from ARDS is not greater in White females.
D) The risk for mortality from ARDS is greater for men than for women.
Page Ref: 1094
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Describe the etiology of ARDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

14) Which action will the nurse take to prevent the development of ARDS in a hospitalized client?
A) Perform postural drainage for clients with respiratory congestion.
B) Elevate the head of the bed for clients who are ingesting food.
C) Provide smoking cessation literature to clients who smoke.
D) Administer oxygen as ordered by the healthcare provider.
Answer: B
Explanation: A) Performing postural drainage will not prevent ARDS.
B) Aspiration of gastric contents is a major risk factor for developing ARDS. Therefore, simple interventions such as elevating the head of the bed for clients who are ingesting food can help prevent ARDS.
C) Although smoking may increase the risk for ARDS, it is not a direct cause of ARDS, so smoking cessation literature will not prevent ARDS in hospitalized clients.
D) Administering oxygen will not prevent ARDS.
Page Ref: 1095
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Compare methods for preventing ARDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

15) The nurse is caring for a woman who is 32 weeks pregnant and requires mechanical ventilation for ARDS. In addition to standard nursing interventions for adult clients with ARDS, which special interventions need to be implemented for this client?
A) Inducing labor
B) Administering nitric oxide and corticosteroids
C) Providing nutritional support
D) Fetal monitoring
Answer: D
Explanation: A) Not all pregnant women with ARDS will need immediate emergency delivery of the neonate.
B) Administering nitric oxide and corticosteroids are interventions for all adult clients with ARDS, not only pregnant women.
C) Providing nutritional support is an intervention for all adult clients with ARDS, not only pregnant women.
D) Care for pregnant clients with ARDS who are at least at 20-24 weeks' gestation should include close fetal monitoring for potential emergency delivery. If the ARDS leads to compromised placental oxygen transfer, the neonate should be delivered immediately for the best outcome.
Page Ref: 1102
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.A. Analyze acute respiratory distress syndrome (ARDS) as it relates to oxygenation. Differentiate care of patients with ARDS across the lifespan.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with acute respiratory distress syndrome.

Exemplar 15.B Asthma

1) The nurse is providing care to a client admitted after experiencing an acute asthma attack. Which assessment findings should the nurse identify as signs that the client has progressed to respiratory failure? **Select all that apply.**
A) Retractions and fatigue
B) Tachycardia and tachypnea
C) Inaudible breath sounds
D) Diffuse wheezing and the use of accessory muscles when inhaling
E) Reduced wheezing and an ineffective cough
Answer: C, E
Explanation: A) Retractions and fatigue indicate a progression of the severity of the symptoms and may require nursing intervention, but they do not indicate respiratory failure.
B) During an asthma attack, tachycardia and tachypnea are common. They are early symptoms of the disease process and can be addressed without urgency.
C) Inaudible breath sounds indicate that the client is progressing to respiratory failure, and immediate interventions are necessary.
D) Diffuse wheezing and the use of accessory muscles when inhaling indicate a progression of the severity of the symptoms and may require nursing intervention, but they do not indicate respiratory failure.
E) Reduced wheezing and ineffective cough indicate that the client is progressing to respiratory failure, and immediate interventions are necessary.
Page Ref: 1120
Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Identify the clinical manifestations of asthma.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

2) Friends of a client hospitalized with asthma would like to bring the client a gift. Which gift should the nurse recommend for this client?
A) A basket of flowers
B) A stuffed animal
C) Fruit and candy
D) A book
Answer: D
Explanation: A) Flowers should be avoided.
B) Items that may contain dust, such as a stuffed animal, should be avoided.
C) Specific foods must be avoided.
D) Objects void of irritants, such as a book, would be an appropriate gift.
Page Ref: 1109
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Compare methods for preventing asthma.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

3) The nurse is teaching environmental control to the parents of a child with asthma. Which statement by the parents indicates effective teaching?
A) "We'll be sure to use the fireplace often to keep the house warm in the winter."
B) "We will replace the carpet in our child's bedroom with tile."
C) "We'll keep the plants in our child's room dusted."
D) "We're glad the dog can continue to sleep in our child's room."
Answer: B
Explanation: A) Smoke from fireplaces should be eliminated.
B) Control of dust in the child's bedroom is an important aspect of environmental control for asthma management, and replacing the carpeting in the child's bedroom with tile flooring will reduce dust.
C) When possible, plants should not be kept in the home.
D) When possible, pets should not be kept in the home.
Page Ref: 1109
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Compare methods for preventing asthma.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

4) A client diagnosed with asthma has a respiratory rate of 28 at rest with audible wheezes upon inspiration. Based on this data, which problem should the nurse make a priority?
A) Impaired airway clearance
B) Impaired tissue perfusion
C) Ineffective breathing pattern
D) Inability to tolerate activity
Answer: C
Explanation: A) Not enough information is provided to determine whether the client has impaired airway clearance.
B) Not enough information is provided to determine whether the client has impaired tissue perfusion.
C) The client is experiencing an increased respiratory rate and is wheezing, which is an ineffective breathing pattern.
D) Not enough information is provided to determine whether the client has activity intolerance.
Page Ref: 1120
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with asthma.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

5) A client asks why asthma medication is needed even though the client's last attack was several months ago. Which response by the nurse is appropriate?
A) "The medication needs to be taken or your lungs will be severely damaged, and we will not be able to prevent an acute attack."
B) "The medication needs to be taken indefinitely according to your doctor, so you should discuss this with him."
C) "The medication is still needed to decrease inflammation in your airways and help prevent an attack."
D) "The medication needs to be taken for at least a year; then, if you have not had an acute attack, you can stop it."
Answer: C
Explanation: A) Telling a client that lungs will be severely damaged is nontherapeutic; the inability to prevent an acute attack in this client is not true.
B) The nurse is able to answer the client's question; it does not need to be referred to the physician.
C) Effective treatment of asthma includes long-term treatment to prevent attacks and decrease inflammation.
D) Long-term treatment of asthma continues indefinitely, not for just 1 year.
Page Ref: 1112
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with asthma.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

6) The nurse is instructing a client who is prescribed ipratropium (Atrovent) for asthma. Which should be included in this client's teaching? **Select all that apply.**
A) Take no more than the prescribed number of doses each day.
B) Rinse the mouth after taking this medication.
C) Take on an empty stomach.
D) Take with meals or a full glass of water.
E) Use hard candy or drink extra fluids to help with a dry mouth.
Answer: A, E
Explanation: A) Appropriate teaching for a client prescribed ipratropium (Atrovent) includes only taking the prescribed number of doses each day to prevent a drug overdose.
B) The mouth does not need to be rinsed after taking this medication as this medication is not a corticosteroid, but an anticholinergic agent.
C) This medication does not need to be taken on an empty stomach.
D) This medication does not need to be taken with meals or a full glass of water.
E) Appropriate teaching for a client prescribed ipratropium (Atrovent) includes using hard candy or extra fluids to decrease dry mouth.
Page Ref: 1087
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with asthma.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

7) The nurse is planning care for a young adolescent client diagnosed with asthma. Which evidence-based, age-appropriate interventions will the nurse include in the plan of care? **Select all that apply.**

A) Referring to a peer-led support group
B) Teaching the parents how to administer maintenance medication prior to teaching the client
C) Assessing peer support when planning care
D) Collaborating with teachers for support in the school setting
E) Telling the client to avoid medication while at school

Answer: A, C, D

Explanation: A) Age-appropriate, evidence-based interventions for a young adolescent client diagnosed with asthma include referral to a peer-led support group.

B) While it is appropriate to include the parents in the educational process, the client should be taught how to administer medications prior to teaching the parents.

C) Age-appropriate, evidence-based interventions for a young adolescent client diagnosed with asthma include assessing peer support of the client.

D) Age-appropriate, evidence-based interventions for a young adolescent client diagnosed with asthma include collaborating with teachers to ensure the client has the necessary support in the school setting.

E) Avoiding medication administration while in school could lead to an acute asthma attack.

Page Ref: 1117, 1121

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Differentiate care of patients with asthma across the lifespan.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

8) The nurse instructs a client with asthma on bronchodilator therapy. Which statement indicates client understanding of how the drug works?
A) "The medication widens the airways by causing airway muscle contraction."
B) "The medication widens the airways by causing airway muscle relaxation."
C) "The medication widens the airways by decreasing histamine production."
D) "The medication widens the airways by decreasing mucus production."
Answer: B
Explanation: A) Bronchodilators stimulate bronchiolar smooth muscle relaxation, not contraction.
B) Bronchodilators stimulate bronchiolar smooth muscle relaxation.
C) Bronchodilators do not decrease the production of histamine.
D) Bronchodilators do not decrease the production of mucus.
Page Ref: 1112
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with asthma.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

9) The nurse working on a pediatric unit is caring for a client newly diagnosed with asthma. Which assessment data indicate impending respiratory failure and the need for immediate intervention? **Select all that apply.**

A) Shallow respirations
B) Slightly diminished breath sounds
C) Decreased wheezing
D) Increased crackles
E) Increased respiratory rate

Answer: A, C

Explanation: A) Respiratory status can change rapidly during an acute asthma attack. Slowed, shallow respirations may indicate exhaustion and impending respiratory failure. Immediate intervention is necessary.

B) Respiratory status can change rapidly during an acute asthma attack. Significantly diminished breath sounds may indicate exhaustion and impending respiratory failure.

C) Respiratory status can change rapidly during an acute asthma attack. Decreased wheezing may indicate exhaustion and impending respiratory failure.

D) Increased crackles are usually associated with heart failure and are not an indication of respiratory failure.

E) An increased respiratory rate indicates respiratory compromise, but not respiratory failure.

Page Ref: 1110

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

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Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Identify the clinical manifestations of asthma.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

10) The nurse is providing care to a client with asthma. When developing the client's plan of care, which intervention would be most appropriate to promote effective gas exchange?
A) Provide adequate rest periods
B) Reduce excessive stimuli
C) Assist with activities of daily living
D) Place in Fowler position
Answer: D
Explanation: A) Providing adequate rest periods prevents fatigue and reduces oxygen demands.
B) Reducing excessive stimuli promotes rest.
C) Assisting with activities of daily living conserves energy and reduces oxygen demands.
D) Placing in Fowler position facilitates breathing and lung expansion, promoting airway clearance.
Page Ref: 1120
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with asthma.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

11) The nurse is reviewing discharge instructions with a client who is newly diagnosed with asthma. Which client statement indicates a need for further teaching?
A) "I need to rinse my mouth after every use of my inhaler."
B) "I need to take my montelukast at least 2 hours before exercising."
C) "When inhaling two different medications, I should use the bronchodilator last."
D) "Because I am on theophylline, I will need to have therapeutic blood levels drawn."
Answer: C
Explanation: A) The mouth should be rinsed after using an inhaler.
B) Montelukast should be taken 2 hours before exercising.
C) When using two different medications taken by inhalation, the bronchodilator should always be used first. This helps open the airways to enhance the effectiveness of the second medication.
D) Theophylline levels are needed to determine if the dosage needs to be adjusted.
Page Ref: 1112
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with asthma.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

12) Which pathophysiologic stimulus should the nurse explain that initiates asthma?
A) Bronchoconstriction
B) Inflammation in the airways
C) Airway edema
D) Mucus secretion
Answer: B
Explanation: A) Inflammation can lead to bronchoconstriction.
B) In asthma, the airways are in a persistent state of inflammation, and this is the primary stimulus that initiates asthma.
C) Inflammation causes airway edema.
D) Inflammation causes increased mucus secretion.
Page Ref: 1107
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Describe the pathophysiology of asthma.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

13) Which triggers can stimulate an acute asthma attack? **Select all that apply.**
A) Stress
B) Animal dander
C) Loud noises
D) Exercise
E) Bright lights
Answer: A, B, D
Explanation: A) Stress is a known trigger of asthma.
B) Animal dander is a known trigger of asthma.
C) Loud noises may trigger hearing loss or headaches, but they will not trigger asthma.
D) Exercise is a known trigger of asthma.
E) Bright lights are not known to trigger asthma.
Page Ref: 1107
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Describe the etiology of asthma.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

14) The nurse is collecting a health history for a 12-month-old child. The child lives in a home where both parents smoke, and the child has had respiratory syncytial virus twice since birth. The child's older sister was recently diagnosed with asthma. Which is this child's risk of developing asthma later in life?
A) Above average
B) Average
C) Below average
D) Well below average
Answer: A
Explanation: A) Risk factors for asthma include exposure to air pollution, including secondary smoke from cigarettes, and early exposure to respiratory syncytial virus. Genetic factors may also play a role in asthma development. Because of the presence of these risk factors, this child has an above average risk of developing asthma later in life.
B) The child has a greater than average risk for developing asthma later in life.
C) The child's risk for developing asthma is greater than below average.
D) The child's risk for developing asthma is greater than well below average.
Page Ref: 1107
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Summarize risk factors for asthma.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

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15) An older adult client experiencing repeated exacerbations of asthma reports difficulty holding the inhaler and remembering to take medications. Which problem should the nurse make a priority for this client?
A) Insufficient knowledge
B) Inadequate health management skills
C) Anxiety
D) Ineffective breathing pattern
Answer: B
Explanation: A) The client appears to have adequate knowledge about how to cope with the condition.
B) Based on the frequency of exacerbations, problems using the inhaler, and difficulty remembering to take medications, the priority problem for this client would be inadequate health management skills.
C) There is no evidence that the client is experiencing anxiety.
D) There is no evidence that the client is having a problem with the breathing pattern.
Page Ref: 1120
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 15.B. Analyze asthma as it relates to oxygenation. Differentiate care of patients with asthma across the lifespan.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with asthma.

Exemplar 15.C Chronic Obstructive Pulmonary Disease

1) Which assessment finding by the nurse supports the diagnosis that a client is in the early stages of chronic obstructive pulmonary disease (COPD)?
A) Dysrhythmias
B) Cyanotic nail beds
C) Clubbing of the fingers
D) Cough in the morning producing clear sputum
Answer: D
Explanation: A) Enlargement and thickening of the right ventricle of the heart often results in dysrhythmias.
B) With the progression of COPD, the body compensates by producing extra red blood cells. These extra blood cells clog the small blood vessels of the fingers, leading to the development of cyanotic nail beds.
C) With the progression of COPD, the body compensates by producing extra red blood cells. These extra blood cells clog the small blood vessels of the fingers, leading to the development of clubbing of the fingertips.
D) The earliest-presenting symptom of COPD is coughing in the morning with clear sputum unless the client develops an infection, in which case the sputum would become yellow or green in color.
Page Ref: 1125
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Identify the clinical manifestations of COPD.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

2) The nurse is providing care to a client diagnosed with chronic obstructive pulmonary disease (COPD) after years of experiencing emphysema. Which clinical manifestation does the nurse anticipate when assessing this client?

A) Tachycardia

B) Cough

C) Barrel chest

D) Wheezing

Answer: C

Explanation: A) Tachycardia is not specific to COPD caused by emphysema.

B) Coughing is not specific to COPD caused by emphysema.

C) Barrel chest occurs because the lungs are chronically overinflated with air, so the rib cage stays partially expanded.

D) Wheezing is not specific to COPD caused by emphysema.

Page Ref: 1126

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Identify the clinical manifestations of COPD.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

3) The nurse is providing care to a client diagnosed with chronic obstructive pulmonary disease (COPD). Which factors in the client's history support the current diagnosis? **Select all that apply.**

A) Working in an industrial environment
B) Working in an office setting with air conditioning
C) History of asthma
D) Current cigarette smoking
E) Playing golf several times a week

Answer: A, C, D

Explanation: A) Risk factors associated with the development of COPD include working in an industrial environment.
B) Working in an office setting with air conditioning is not a risk factor for the development of COPD.
C) Risk factors associated with the development of COPD include a history of asthma.
D) Risk factors associated with the development of COPD include cigarette smoking.
E) Playing golf several times a week is not a risk factor for the development of COPD.

Page Ref: 1125
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Summarize the risk factors for COPD.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

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4) The nurse is caring for a Spanish-speaking client admitted for exacerbation of chronic obstructive pulmonary disease (COPD). The client speaks very little English and is a smoker. Which action would be the most beneficial for this client?
A) Have the adult child of the client translate during the assessment process
B) Encourage aerobic activity
C) Encourage the client to write down questions prior to seeing the healthcare provider
D) Obtain educational materials about smoking cessation written in Spanish.
Answer: D
Explanation: A) Relatives should not be used as medical interpreters because of the need for knowledge of medical terminology.
B) Encouraging aerobic activity is not an appropriate intervention for a client diagnosed with COPD.
C) Writing down questions might be appropriate for an English-speaking client but will not be appropriate for a Spanish-speaking client being treated in an English-speaking healthcare environment.
D) A Spanish-speaking client who smokes and is diagnosed with COPD requires information regarding smoking cessation. For clients who do not speak English, it is appropriate for the nurse to obtain written education material for the client in the client's native language, Spanish.
Page Ref: 1125
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies:.2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Compare methods of preventing COPD.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

5) The nurse is planning care for the client diagnosed with chronic obstructive pulmonary disease (COPD) who has a breathing rate of 32 per minute, elevated blood pressure, and fatigue. Which problem is the priority for this client?
A) Inadequate family coping skills
B) Impaired airway clearance
C) Anxiety
D) Ineffective breathing pattern

Answer: D

Explanation: A) There is no information to support inadequate family coping skills.
B) There is no information to support impaired airway clearance, as there is no mention that the client is coughing.
C) There is no information to support anxiety.
D) The client's respiratory rate of 32 per minute is an indication of an ineffective breathing pattern. The elevated blood pressure and fatigue are indications of a compromised respiratory status. The problem of ineffective breathing pattern would be the priority for the client at this time.

Page Ref: 1130

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with COPD.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

6) The nurse is planning care for a client diagnosed with chronic obstructive pulmonary disease (COPD). Which interventions should the nurse select to address the client's ineffective breathing pattern? **Select all that apply.**
A) Instruct in pursed-lip breathing
B) Teach visualization and meditation
C) Deep breathing and coughing every hour
D) Instruct in abdominal breathing
E) Provide oxygen 2 liters nasal cannula.
Answer: A, B, D
Explanation: A) Techniques used to instruct a client to control the breathing pattern include pursed-lip breathing.
B) Techniques used to instruct a client to control the breathing pattern include relaxation such as visualization and meditation.
C) Deep breathing and coughing should be done every 2 hours to help keep the airway clear and prevent the pooling of secretions, not to control the breathing pattern.
D) Techniques used to instruct a client to control the breathing pattern include abdominal breathing.
E) Providing oxygen 2 liters per nasal cannula will not improve the client's breathing pattern.
Page Ref: 1131
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with COPD.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

7) A client diagnosed with chronic obstructive pulmonary disease (COPD) has a pulse oximetry reading of 93%, increased red blood cell and white blood cell counts, temperature of 101°F, pulse 100 bpm, respirations 35 bpm, and a chest x-ray that showed a flattened diaphragm with infiltrates. Based on this data, which prescription does the nurse question for this client?

A) Antibiotic therapy
B) Nonsteroidal anti-inflammatory agents (NSAIDs)
C) Oxygen by nasal cannula at 3-4 liters/minute
D) Bronchodilators such as adrenergic stimulating drugs or anticholinergic agents

Answer: C

Explanation: A) A prescription for antibiotics is expected for this client's condition.

B) NSAIDs is expected for this client's condition.

C) Based on the hypoxic drive theory and the need for hypoxia to stimulate breathing, oxygen saturation for clients with COPD should be greater than 90%. Therefore, this client may not require oxygen administration at this time, and oxygen at 3-4 L/min may lead to respiratory depression or respiratory failure.

D) Bronchodilators are expected for this client's condition.

Page Ref: 1128

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with COPD.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

8) The nurse is planning care for a client diagnosed with chronic obstructive pulmonary disease (COPD). Which interventions should the nurse select to meet nutritional needs? **Select all that apply.**

A) Encourage a diet high in protein and fats.
B) Keep snacks to a minimum.
C) Provide frequent small meals with between-meal supplements.
D) Encourage carbohydrate-rich foods to provide needed calories for energy.
E) Suggest the client eat three meals per day to maintain energy needs.

Answer: A, C

Explanation: A) A diet high in protein and fats is recommended to minimize carbon dioxide production during metabolism.

B) Three meals with minimal snacking will not help maintain intake and reduce fatigue associated with eating.

C) Frequent small meals with between-meal supplements helps maintain intake and reduce fatigue associated with eating.

D) A diet without excess carbohydrates is recommended to minimize carbon dioxide production during metabolism.

E) Three meals may not be sufficient for the client's energy needs.

Page Ref: 1131

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with COPD.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

9) The nurse is evaluating care provided to a client diagnosed with chronic obstructive pulmonary disease (COPD). Which observation would indicate that care provided to this client has been effective?

A) Client conducts morning care and ambulates in room while maintaining an oxygen saturation of 92% on room air per oximetry reading.

B) Client needs assistance with morning care and meals due to shortness of breath.

C) Client states family members are discussing admission to a nursing home for continuing care.

D) Client leaves hospital unit to smoke outside four times a day.

Answer: A

Explanation: A) Evidence that care provided to a client with COPD was successful would be the client conducting morning care and ambulating in the room while maintaining an oxygen saturation of 92%. This outcome identifies the client's ability to maintain adequate oxygenation and perform activities of daily living.

B) The client who needs assistance with morning care and meals because of shortness of breath needs additional interventions.

C) The client who states that family would prefer the client go to a nursing home may or may not have been positively affected by the interventions; not enough information is provided to know.

D) The client's leaving the unit to smoke suggests that care has not been effective.

Page Ref: 1132

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies:. 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with COPD.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

10) The nurse is planning care for a client diagnosed with chronic obstructive pulmonary disease (COPD). When planning care for this client, which interventions are appropriate to enhance the client's breathing pattern? **Select all that apply.**

A) Provide adequate rest periods.
B) Assist with activities of daily living (ADLs).
C) Educate on relaxation techniques.
D) Educate on pursed-lip breathing.
E) Administer a cough suppressant.

Answer: A, B, C, D

Explanation: A) Providing adequate rest periods prevents fatigue and reduces oxygen demands.
B) Assisting with ADLs prevents fatigue and reduces oxygen demands.
C) Relaxation techniques reduce anxiety and its effect on the respiratory rate.
D) Pursed-lip breathing helps keep airways open by maintaining positive pressure.
E) A cough suppressant is not an appropriate medication for a client with COPD as it is important for the client to expel mucus to maintain adequate oxygenation.

Page Ref: 1131
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with COPD.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

11) The nurse caring for a client diagnosed with chronic obstructive pulmonary disease (COPD) is educating the client on effective coughing techniques. Which statement made by the client indicates a need for further teaching?
A) "I should inhale by sniffing."
B) "I should exhale sharply with a ‘huff'."
C) "I should limit my fluid intake to 1-1.5 quarts daily."
D) "I should cough twice and then rest."
Answer: C
Explanation: A) The client should inhale by sniffing.
B) A sharp huff should be done when exhaling.
C) Adequate fluid intake is at least 2-2.5 quarts of fluid daily, so the statement about drinking 1-1.5 quarts daily indicates the need for further teaching.
D) The client should cough twice and then rest.
Page Ref: 1131
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with COPD.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

12) The nurse is assigned to care for a client admitted to the hospital with chronic obstructive pulmonary disease (COPD). Which medication does the nurse anticipate to decrease this client's risk for developing a respiratory infection?
A) A broad-spectrum antibiotic
B) A bronchodilator
C) A corticosteroid
D) An influenza vaccine
Answer: D
Explanation: A) A broad-spectrum antibiotic may be prescribed if infection is suspected but would not be ordered to reduce the risk of developing an infection.
B) Bronchodilators are not used to prevent infections.
C) Corticosteroids are not used to prevent infections.
D) An influenza vaccine may be ordered to reduce the risk of respiratory infections.
Page Ref: 1128
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with COPD.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

13) The nurse is providing care to a client recently diagnosed with chronic obstructive pulmonary disease (COPD). Which conditions will the nurse include when teaching the client's family about the types of COPD?
A) Asthma and bronchitis
B) Asthma and emphysema
C) Bronchitis and emphysema
D) Emphysema and atelectasis
Answer: C
Explanation: A) Asthma is not a type of COPD.
B) Asthma is not a type of COPD.
C) Although one or the other may dominate, COPD typically includes components of both chronic bronchitis and emphysema, two distinctly different processes.
D) Atelectasis is not a type of COPD.
Page Ref: 1124
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Describe the pathophysiology of COPD.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

14) Which reason should the nurse identify as a genetic cause of COPD?
A) Alpha-1 antitrypsin deficiency
B) A defect in the CFTR gene
C) A mutation in the superoxide dismutase 1 gene
D) Mutations in the human leukocyte antigen
Answer: A
Explanation: A) COPD can be caused by a genetic deficiency in alpha-1 antitrypsin, which is necessary for normal lung development and function.
B) A defect in the CFTR gene causes cystic fibrosis.
C) A mutation in the superoxide dismutase 1 gene causes amyotrophic lateral sclerosis (ALS), a neuromuscular disease that can reduce an individual's ability to control breathing muscles.
D) Certain mutations in the human leukocyte antigen (HLA) allele are associated with increased risk of sarcoidosis, which causes inflammatory cells to collect in the lungs.
Page Ref: 1124
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Describe the etiology of COPD.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

15) Which action should the nurse take to help reduce a client's risk for developing COPD?
A) Providing smoking cessation resources
B) Encouraging clients to receive vaccinations
C) Referring clients to a nutritionist
D) Providing references to local fitness facilities
Answer: A
Explanation: A) The primary cause of COPD is smoking, so nurses can reduce the risk of clients developing COPD by providing smoking cessation resources and encouraging clients to follow through with plans to stop smoking.
B) Vaccinations do not reduce the risk of developing COPD.
C) Nutrition changes do not reduce the risk of developing COPD.
D) Healthy exercise habits do not reduce the risk of developing COPD.
Page Ref: 1125
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.C. Analyze chronic obstructive pulmonary disease (COPD) as it relates to oxygenation. Compare methods of preventing COPD.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with chronic obstructive pulmonary disease.

Exemplar 15.D Cystic Fibrosis

1) Which ion should the nurse identify that cannot be regulated in clients with cystic fibrosis?
A) Chloride
B) Sodium
C) Calcium
D) Potassium
Answer: A
Explanation: A) Cystic fibrosis stems from dysfunction of the CFTR protein, which controls movement of chloride into and out of cells.
B) Cystic fibrosis stems from dysfunction of the CFTR protein, which may also affect transport of sodium in the form of sodium chloride, but the primary ion affected is chloride.
C) Regulation of calcium is not affected in cystic fibrosis.
D) Regulation of potassium is not affected in cystic fibrosis.
Page Ref: 1135
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.D. Analyze cystic fibrosis as it relates to oxygenation. Describe the pathophysiology of cystic fibrosis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with cystic fibrosis.

2) A couple learns that they are both carriers of the CFTR gene for cystic fibrosis (CF). Which percent chance will this couple have of any offspring inheriting two abnormal genes and developing CF?
A) 100
B) 75
C) 50
D) 25
Answer: D
Explanation: A) There is not a 100% chance that the offspring will inherit two abnormal genes and develop CF.
B) There is not a 75% chance that the offspring will inherit two abnormal genes and develop CF.
C) When both parents are carriers of the CF gene, there is a 50% possibility that the child will be a carrier of one CF gene.
D) When both parents are carriers of the CF gene, each conception allows for a 25% possibility that two abnormal genes will be passed to the child. Each conception also allows for a 25% possibility that the child will not carry the CF gene.
Page Ref: 1136
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.D. Analyze cystic fibrosis as it relates to oxygenation. Summarize the risk factors for cystic fibrosis.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with cystic fibrosis.

3) Besides the respiratory system, which system would be critical for the nurse to assess in a client recently diagnosed with cystic fibrosis?
A) Nervous system
B) Gastrointestinal system
C) Musculoskeletal system
D) Urinary system
Answer: B
Explanation: A) Cystic fibrosis does not affect the nervous system.
B) In addition to respiratory alterations, clients with cystic fibrosis often have alterations to the gastrointestinal system. In particular, obstruction of pancreatic ducts by thick mucus impairs the production of pancreatic enzymes that are necessary for food digestion. This results in malnutrition, chronic diarrhea, and impaired insulin production.
C) Cystic fibrosis does not affect the musculoskeletal system.
D) Cystic fibrosis does not affect the urinary system directly.
Page Ref: 1136
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.D. Analyze cystic fibrosis as it relates to oxygenation. Identify the clinical manifestations of cystic fibrosis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with cystic fibrosis.

4) The nurse is caring for an 18-month-old client who is newly diagnosed with cystic fibrosis. The client is currently hospitalized due to a *Pseudomonas aeruginosa* infection in the lungs. The client's vital signs are P 138, R 43, T 101.3°F, BP 86/40, SpO_2 88%. The client is coughing up thick, green mucus. Which independent nursing intervention can the nurse implement to improve the client's oxygenation?
A) Administration of CFTR modulators
B) Percussion and postural drainage
C) Nutritional counseling
D) Teaching the client to cough into a tissue
Answer: B
Explanation: A) Administration of CFTR modulators is a collaborative intervention.
B) Percussion and postural drainage are chest physical therapy techniques that the nurse can implement to help clear the client's lungs of mucus, which will improve oxygenation.
C) Nutritional counseling is a collaborative intervention.
D) Teaching the client to cough into a tissue is an infection control measure. It will not improve oxygenation compared to any other type of coughing. In addition, the client is likely too young to understand and follow through with this teaching consistently.
Page Ref: 1138, 1142-1143
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.D. Analyze cystic fibrosis as it relates to oxygenation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with cystic fibrosis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with cystic fibrosis.

5) A 7-year-old client is hospitalized due to complications related to cystic fibrosis. The nurse is responsible for administering medications and performing chest physical therapy. In which order should the nurse perform these actions?
A) Place the client in a position for postural drainage
B) Administer inhaled albuterol
C) Administer inhaled hypertonic saline
D) Perform percussion on the client's back and chest
E) Administer oxygen by nasal cannula
Answer: B, C, A, D, E
Explanation: Inhaled medications should be administered before placing the client in a position for postural drainage and performing percussion. In particular, albuterol, a bronchodilator, should be administered before chest physical therapy and before other inhaled medications. Therefore, albuterol should be administered first, followed by hypertonic saline. Then chest physical therapy should be performed by first placing the client in a position for postural drainage and then performing percussion on the client's back and chest. After the medications and therapy are completed, administration of oxygen by nasal cannula will be more effective.
Page Ref: 1146
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.D. Analyze cystic fibrosis as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with cystic fibrosis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with cystic fibrosis.

6) A pre-adolescent female client with cystic fibrosis asks when menstruation should begin. Which response by the nurse is correct?
A) "Usually, girls with cystic fibrosis start menstruating earlier than their peers."
B) "It is normal for girls with cystic fibrosis to start their period at age 16. Just be patient."
C) "Some girls with cystic fibrosis do not experience menstruation due to nutritional problems."
D) "Because secretions are thicker in people with cystic fibrosis, your period will be very heavy once it starts."
Answer: C
Explanation: A) Adolescent females do not usually start menstruating earlier than their peers.
B) Adolescent females do not usually start having menstrual periods at age 16.
C) Disease-related nutritional deficiencies may interfere with normal reproductive development, causing some girls with cystic fibrosis to not experience menstruation.
D) CF affects the thickness of mucus secretions, but it does not affect the thickness of the blood.
Page Ref: 1144
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 15.D. Analyze cystic fibrosis as it relates to oxygenation. Differentiate care of patients with cystic fibrosis across the lifespan.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with cystic fibrosis.

7) The nurse is providing teaching to the client who is pregnant and has cystic fibrosis. The nurse should explain that the client is at increased risk for which condition?
A) Emergency delivery
B) Gestational diabetes
C) Placenta previa
D) Spontaneous abortion
Answer: B
Explanation: A) Many clients are able to have a natural birth, so planning ahead for an emergency delivery is not necessary.
B) Because of changes in the secretion of insulin in many clients with cystic fibrosis, pregnant women who do not already have diabetes are at increased risk of developing gestational diabetes during pregnancy.
C) Cystic fibrosis does not increase the client's risk of placenta previa.
D) Cystic fibrosis does not increase the client's risk of spontaneous abortion.
Page Ref: 1090
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 15.D. Analyze cystic fibrosis as it relates to oxygenation. Differentiate care of patients with cystic fibrosis across the lifespan.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with cystic fibrosis.

Exemplar 15.E Respiratory Syncytial Virus/Bronchiolitis

1) The mother of a 5-month-old baby who attends daycare, is concerned because the child has developed a runny nose, cough, and low-grade fever over the last few days. These symptoms are consistent with which condition?
A) Meningitis
B) Respiratory syncytial virus (RSV)/ bronchiolitis
C) Bronchitis
D) The common cold
Answer: B
Explanation: A) A runny nose and cough are not symptoms associated with meningitis.
B) The typical clinical presentation of respiratory syncytial virus (RSV)/ bronchiolitis in otherwise healthy children begins 3-5 days after exposure to the virus. The early signs of a mild infection include rhinorrhea or a runny nose, cough, irritability, and a low-grade fever for 1-3 days.
C) Bronchitis has a distinctive cough and may or may not be associated with a fever.
D) A fever is not associated with the common cold.
Page Ref: 1151
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Identify the clinical manifestations of RSV/bronchiolitis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

2) The mother of an 8-month-old baby who has developed respiratory syncytial virus (RSV)/bronchiolitis wants to know which factors contribute to the risk of contracting RSV. Which response by the nurse is appropriate?
A) "There is a higher risk in children who are being breastfed."
B) "There is no way to avoid the illness."
C) "There is a higher risk in children who are exposed to secondary cigarette smoke."
D) "It is seen more frequently in children who do not attend daycare."
Answer: C
Explanation: A) The risk of infection with RSV is higher for infants and toddlers who are not breastfed.
B) RSV can be avoided by limiting risk factors.
C) The risk of infection with RSV is higher for infants and toddlers who live in homes with secondary cigarette exposure.
D) The risk of infection with RSV is higher for infants and toddlers who attend daycare.
Page Ref: 1151
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Summarize the risk factors for RSV/bronchiolitis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

3) The nurse observes a toddler, admitted with possible respiratory syncytial virus (RSV)/ bronchiolitis, grunting with expiration. Which action by the nurse is appropriate?
A) Assist the child to clear the nasal passages.
B) Limit fluids.
C) Suction the airway to relieve the obstruction.
D) Lay the child on his back.
Answer: C
Explanation: A) Assisting the child to clear the nasal passages would be applicable if the child were experiencing rhinorrhea.
B) Fluids should be increased to thin secretions.
C) Grunting is seen with partial airway obstruction caused by increased secretions and edema. The nurse should suction the airway to relieve the obstruction.
D) Laying the child on his back will not improve the child's ability to breathe.
Page Ref: 1154
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with RSV/bronchiolitis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

4) The nurse assesses fatigue in an infant with acute bronchiolitis due to respiratory syncytial virus (RSV). Which problem would be most appropriate for the infant?
A) Acute pain
B) Inadequate perfusion of tissues
C) Inability to tolerate activity
D) Decreased cardiac output
Answer: C
Explanation: A) Pain is not usually associated with acute bronchiolitis.
B) Tissue perfusion is not affected by this respiratory disease process.
C) Activity intolerance is a problem because of the imbalance between oxygen supply and demand. Increased levels of fatigue may indicate the disease is more severe.
D) Cardiac output is not compromised during an acute phase of bronchiolitis.
Page Ref: 1154
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with RSV/bronchiolitis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

5) The nurse is planning care for a child with respiratory syncytial virus (RSV)/ bronchiolitis. Which interventions should the nurse use to promote airway clearance? **Select all that apply.**

A) Weigh daily.
B) Monitor vital signs and pulse oximetry.
C) Remove secretions with a bulb syringe.
D) Weigh diapers.
E) Provide frequent rest periods.

Answer: B, C

Explanation: A) Weighing daily would be appropriate for a problem with nutrition.
B) Interventions appropriate to promote airway clearance include monitoring vital signs and pulse oximetry
C) Interventions appropriate to promote airway clearance include removing secretions with a bulb syringe.
D) Weighing diapers would be appropriate for a problem with fluid balance.
E) Frequent rest periods would be appropriate for a problem with activity tolerance.

Page Ref: 1154
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with RSV/bronchiolitis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

6) An infant with respiratory syncytial virus (RSV)/ bronchiolitis is prescribed intubation to maintain an adequate airway. With which healthcare professional will the nurse collaborate to maintain the endotracheal tube and ventilation?
A) An advanced practice nurse
B) The primary healthcare provider
C) A respiratory therapist
D) A play therapist
Answer: C
Explanation: A) The advanced practice nurse is not responsible for maintaining the client's endotracheal tube and ventilation.
B) Infants who need endotracheal intubation will be closely cared for by the respiratory therapist. The primary healthcare provider is not responsible for maintaining the client's endotracheal tube and ventilation.
C) Infants who need endotracheal intubation will be closely cared for by the respiratory therapist.
D) The play therapist is not responsible for maintaining the client's endotracheal tube and ventilation.
Page Ref: 1152
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with RSV/bronchiolitis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

7) Which prevention strategies would be the most beneficial for the nurse to discuss with the parents of a child who has had repeated admissions for respiratory syncytial virus (RSV)/ bronchiolitis? **Select all that apply.**
A) Do not smoke and avoid all secondhand smoke around the child.
B) Practice frequent hand washing.
C) Encourage physical activity and play.
D) Consider alternatives to sending the child to daycare.
E) Ensure an adequate nutritional intake.
Answer: A, B, D
Explanation: A) Exposure to cigarette smoke and attending daycare are both risk factors for RSV/bronchiolitis. The nurse should discuss with the parents smoking cessation.
B) Frequent hand washing is a primary prevention method for RSV, so this should be practiced by the parents.
C) Physical activity is good for maintaining general health but is not specific for preventing RSV/bronchiolitis.
D) The nurse should discuss with the parents an alternative method of childcare.
E) Nutritional intake is good for maintaining general health but is not specific for preventing RSV/bronchiolitis.
Page Ref: 1151
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Summarize the risk factors for RSV/bronchiolitis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

8) The nurse is providing care to a client diagnosed with respiratory syncytial virus (RSV)/ bronchiolitis. Which assessment finding indicates that treatment has been effective?
A) Client ingesting small amounts of clear fluids when encouraged
B) Client resting in bed with limited interest in play or activities
C) Client respiratory rate within normal limits for age
D) Client coughing copious amounts of green sputum and requires occasional suctioning
Answer: C
Explanation: A) The client who is ingesting small amounts of fluids might still be experiencing thickened secretions.
B) The client who is resting in bed with limited interest in play or activities is not demonstrating an improvement in respiratory status.
C) Evidence that care is effective would include normal rate, rhythm, and quality of the breathing patterns for the client's age.
D) If the client is coughing copious amounts of green sputum and requiring occasional suctioning, the interventions have not been effective, as the child still needs assistance with clearing the airway.
Page Ref: 1155
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with RSV/bronchiolitis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

9) The clinic nurse is educating a group of new moms on the risk factors and prevention of respiratory syncytial virus (RSV). What action should the nurse stress as the best way to prevent RSV?
A) Hand washing
B) Monitoring temperature
C) Administering antibiotics
D) Limiting fluid intake
Answer: A
Explanation: A) The best way to prevent RSV is through good hand hygiene and infection-control measures.
B) Monitoring temperature would not prevent infection but would be appropriate for monitoring infection.
C) Administering antibiotics is usually ordered by the physician when a bacterial infection is suspected, not a viral infection.
D) There is no indication of the need to limit fluids, which could potentially produce other complications.
Page Ref: 1151
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Compare methods for preventing RSV/bronchiolitis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

10) Which population should the nurse assigned to care for pediatric clients recognize as having the highest risk of hospitalization due to RSV?
A) Alaskan Native infants
B) African American infants
C) Native American infants
D) Asian American infants
Answer: A
Explanation: A) RSV is a major cause of hospitalization among Alaskan Native infants.
B) RSV is not a major cause of hospitalization among African American infants.
C) RSV is not a major cause of hospitalization among Native American infants.
D) RSV is not a major cause of hospitalization among Asian American infants.
Page Ref: 1151
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Describe the etiology of RSV/bronchiolitis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

11) The nurse working in the emergency department (ED) is assessing an infant client. Which findings does the nurse anticipate in a child diagnosed with respiratory syncytial virus (RSV)? **Select all that apply.**

A) Rhinorrhea
B) Irritability
C) Grunting
D) Bradypnea
E) Tachypnea

Answer: A, C, E

Explanation: A) The early signs of RSV include rhinorrhea.
B) Irritability is not identified as a symptom of RSV.
C) Grunting can occur as respiratory system is compromised.
D) Bradypnea is not a symptom of RSV.
E) Symptoms of RSV include tachypnea.

Page Ref: 1151
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Identify the clinical manifestations of RSV/bronchiolitis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

12) The nurse is developing a plan of care for a toddler diagnosed with respiratory syncytial virus (RSV). Which intervention is inappropriate for this client?
A) Offer small, frequent meals.
B) Encourage to ambulate frequently.
C) Encourage oral intake.
D) Monitor intake and output.
Answer: B
Explanation: A) Small frequent meals is appropriate for this client.
B) It would not be appropriate to encourage frequent ambulation. Nursing interventions should be introduced in an effort to reduce fatigue, such as allowing rest periods.
C) Encouraging oral intake is appropriate for this client.
D) Monitoring intake and output is appropriate for this client.
Page Ref: 1155
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Apply the nursing process in providing culturally competent care to an individual with RSV/bronchiolitis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

13) Which body cells will the nurse identify as being involved in an infection by respiratory syncytial virus (RSV)?
A) Smooth muscle cells in the bronchi and bronchioles
B) Granular pneumonocytes in the alveoli
C) Squamous epithelial cells of the bronchioles and alveoli
D) Macrophages and monocytes of the bronchioles and alveoli
Answer: C
Explanation: A) Respiratory syncytial virus does not infect smooth muscle cells.
B) Respiratory syncytial virus does not infect granular pneumonocytes (the surfactant-secreting cells).
C) Respiratory syncytial virus infects the squamous epithelial cells of the bronchioles and alveoli.
D) Respiratory syncytial does not infect the macrophages and monocytes.
Page Ref: 1151
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Describe the pathophysiology of RSV/bronchiolitis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

14) The nurse is providing care to a 7-month-old child hospitalized with RSV/bronchiolitis. The nurse can expect to provide client teaching to the parents about which medication?
A) Corticosteroids
B) Nebulized epinephrine
C) Antibiotics
D) Nebulized hypertonic saline
Answer: D
Explanation: A) Corticosteroids are not recommended for clients with RSV/bronchiolitis.
B) Nebulized epinephrine is no longer recommended for clients with RSV/bronchiolitis.
C) Because RSV is a virus, antibiotics should not be used.
D) Nebulized hypertonic saline is used to promote mucociliary clearance in hospitalized clients with RSV/bronchiolitis.
Page Ref: 1153
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with RSV/bronchiolitis.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

15) The nurse is assessing an adult client with respiratory syncytial virus (RSV). Which symptom will the nurse expect to assess that is absent in infants with RSV?
A) Rhinorrhea
B) Cough
C) Apnea
D) Headache
Answer: D
Explanation: A) Rhinorrhea is common in both infants and adults with RSV.
B) Cough is common in both infants and adults with RSV.
C) Apnea is more commonly seen in infants, not in adults.
D) Headaches are more commonly assessed in adults with RSV and not infants.
Page Ref: 1153
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Differentiate care of patients with RSV/bronchiolitis across the lifespan.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

16) Which outcome should the nurse select for a 78-year-old resident of a long-term care facility to prevent RSV?
A) The client's airways will remain clear of secretions.
B) The client's fluid intake will meet daily requirements of 2000 mL per day.
C) The client will demonstrate knowledge of proper hand washing techniques.
D) The client will meet daily nutritional needs as provided by a nutritionist.
Answer: C
Explanation: A) An outcome related to airways remaining clear of secretions is more appropriate for an individual who already has RSV.
B) An adequate fluid intake will be beneficial for the client but is not specifically related to preventing infection.
C) RSV is spread by direct contact with contaminated surfaces or an infected individual, so use of proper hand washing techniques can help prevent infection in susceptible individuals.
D) Meeting daily nutritional needs will be beneficial for the client but is not specifically related to preventing infection.
Page Ref: 1151
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 15.E. Analyze RSV/bronchiolitis as it relates to oxygenation. Differentiate care of patients with RSV/bronchiolitis across the lifespan.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with respiratory syncytial virus/bronchiolitis.

Exemplar 15.F Sudden Infant Death Syndrome

1) The pediatric nurse is providing education to a new mother regarding ways to decrease the risk of sudden infant death syndrome (SIDS). Which statement by the nurse is appropriate?
A) "You should keep the baby with you at all times to assess for apnea."
B) "Make sure the baby has a soft blanket and pillow when sleeping."
C) "It is recommended that you place your baby on his back for sleep."
D) "SIDS has been linked to immunizations. I recommend that you avoid immunizing your baby."
Answer: C
Explanation: A) Keeping the infant with the mother at all times is unreasonable and will not prevent SIDS.
B) Soft pillows and blankets also increase the risk for SIDS, so they should not be used.
C) A side-lying or prone position increases the infant's risk of SIDS, so the mother should be taught to always place the baby on his back for sleep
D) Immunizations have no known link to SIDS.
Page Ref: 1157
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Summarize the risk factors for SIDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

2) The nurse is instructing new parents on ways to decrease the risk of sudden infant death syndrome (SIDS) with their newborn son. Which information should be included in these instructions? **Select all that apply.**

A) There is nothing that can be done, so requirements for toys and bedding are of no consequence.

B) Instruct that it is more common in babies from ages 6 months to 18 months.

C) Avoid placing the baby in the prone or side-lying position for sleep.

D) Remind the parents that the syndrome is more common in females than males, and that they have a male child.

E) Do not smoke near the child and reduce all exposure to secondhand smoke.

Answer: C, E

Explanation: A) There are several actions that can be done to prevent the risk of SIDS.

B) Risk factors for SIDS include being under 6 months of age.

C) Sleeping in the prone or side-lying position is a risk factor for the syndrome.

D) Being male is a risk factor for SIDS.

E) The nurse should instruct the parents to not smoke and to reduce all exposure to secondhand smoke to reduce the child's risk of SIDS.

Page Ref: 1156-1157

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Summarize the risk factors for SIDS.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

3) When assessing the risk of a newborn for sudden infant death syndrome (SIDS), which are risk factors that the nurse should consider? **Select all that apply.**
A) Race
B) Gender
C) Father's age
D) Age
E) Eye color
Answer: A, B, D
Explanation: A) SIDS is most common in American Indians and Alaska Natives, followed by non-Hispanic Blacks, non-Hispanic Whites, Hispanics, and Asian or Pacific Islanders.
B) SIDS is most common in males than in females.
C) Father's age is not related to the risk of SIDS.
D) SIDS is most common in infants under 6 months of age.
E) Infant eye color is not related to the risk of SIDS.
Page Ref: 1156-1157
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Summarize the risk factors for SIDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

4) The nurse is providing parenting teaching regarding reducing the risk of sudden infant death syndrome (SIDS). Which teaching point is a priority for the nurse to include?
A) Instruct on side-lying and face-down positions when in the crib.
B) Instruct on face-up position when in the crib.
C) Ensure adequate nutritional intake for the mother and newborn.
D) Encourage good hand washing.
Answer: B
Explanation: A) Side-lying and face-down positions are associated with a higher risk of the syndrome and should not be instructed.
B) The nurse should instruct the mother to place the baby in the face-up position when in the crib.
C) Adequate nutrition does not prevent SIDS.
D) Good hand washing does not prevent SIDS.
Page Ref: 1157
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Apply the nursing process in providing culturally competent care for a family experiencing SIDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

5) The nurse is planning care for a baby born to a mother who smoked during the pregnancy. The mother states that she believes in bed sharing. Which problem would be appropriate for this baby?
A) Potential for SIDS
B) Readiness to improve parenting skills
C) Anxiety
D) Lack of knowledge about SIDS
Answer: A
Explanation: A) The most important problem for the baby at this time is the potential for SIDS. Both bed sharing and the mother smoking during pregnancy are risk factors for SIDS.
B) Readiness to improve parenting skills is a problem for the parent.
C) Anxiety is a problem for the parent.
D) Lack of knowledge about SIDS is a problem for the parent.
Page Ref: 1159
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Apply the nursing process in providing culturally competent care for a family experiencing SIDS.

MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

6) The nurse is planning care for a new mother who smoked during the pregnancy and whose sister lost a child to sudden infant death syndrome (SIDS). Which interventions are appropriate for the nurse to include in the plan of care for the new mother and baby? **Select all that apply.**
A) Information on bottle-feeding the infant
B) Reasons why the child should sleep with others
C) Ages at which the child should receive immunizations
D) Using bedding that is firm
E) Smoking cessation information
Answer: D, E
Explanation: A) The method of feeding is not associated with the syndrome; however, the risk is decreased with breastfeeding, not bottle feeding.
B) Sleeping with others will increase the child's risk of the syndrome and should not be in the plan of care.
C) While age-appropriate immunizations are important for the overall health of the baby, this intervention does not specifically reduce the risk for SIDS.
D) The nurse should instruct the mother to use bedding that is firm.
E) The plan of care to decrease the child's risk of SIDS should include habits to lower the risk of SIDS, one of which is smoking cessation.
Page Ref: 1157, 1160
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

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Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Compare methods for preventing SIDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

7) The nurse is placing a newborn baby in the nursery crib with the baby's back down. The mother tells the nurse that she doubts the baby will be able to sleep that way, as all the family members sleep on their stomachs. Which action by the nurse is appropriate?
A) Instruct the mother that placing the baby on the back will reduce the risk of sudden infant death syndrome (SIDS) and it will not interfere with sleep.
B) Place the baby on the stomach.
C) Suggest the mother place the baby on the stomach when at home.
D) Instruct the mother that babies do not really care in which position they are in but placing on the back is easier to provide care.
Answer: A
Explanation: A) The nurse should instruct the mother that placing the baby on the back will reduce the risk of sudden infant death syndrome, and it will not interfere with the baby's ability to sleep.
B) The nurse should not place the baby on the stomach.
C) The nurse should not suggest that the mother place the baby on the stomach when at home.
D) Placing the baby on the back does not necessarily make it easier to provide care.
Page Ref: 1157, 1160
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Apply the nursing process in providing culturally competent care for a family experiencing SIDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

WwW.EbSm.Ws

8) The nurse is providing supportive care for the parents of an infant who died from sudden infant death syndrome (SIDS). Which action by the nurse is appropriate?
A) Advising the parents that an autopsy is not necessary
B) Refraining from recommending support groups until after the investigation
C) Interviewing the parents to determine the cause of the SIDS incident
D) Contacting the family's spiritual leader for support
Answer: D
Explanation: A) An autopsy will be necessary.
B) Support groups should not be delayed for the investigation.
C) Interviews to determine the cause of death will be the responsibility of the medical examiner and law enforcement agents, not the nurse.
D) The family will need emotional support during this time, including support from the family's spiritual leader.
Page Ref: 1159
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of a family experiencing SIDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

9) The nurse is evaluating care provided to a new mother whose infant is at risk for sudden infant death syndrome (SIDS). Which statement by the mother indicates teaching has been effective?
A) "I need to purchase loose-fitting sheets and blankets for the bed."
B) "I plan to quit smoking."
C) "I will place my baby in a side-lying position for sleep."
D) "I will bottle-feed my baby since breastfeeding is a risk factor for SIDS."
Answer: B
Explanation: A) Loose-fitting sheets and blankets are associated with an increased risk for the syndrome.
B) If the mother of an infant at risk for SIDS expresses her plan to quit smoking, the nursing care has been effective.
C) The prone and side-lying positions increase the risk for the syndrome.
D) The feeding method is not implicated with the syndrome and would not be used to evaluate the plan of care for an infant at risk for SIDS.
Page Ref: 1159
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Apply the nursing process in providing culturally competent care for a family experiencing SIDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

10) A nurse is preparing to educate a group of parents on sudden infant death syndrome (SIDS). Which variables should the nurse highlight as contributing to increased risk of SIDS? **Select all that apply.**
A) Prone sleeping
B) Side sleeping
C) Loose bedding
D) Bed sharing
E) Supine sleeping
Answer: A, B, C, D
Explanation: A) Infants in the prone position are vulnerable because the brainstem abnormality compromises their protective reflexes, such as arousal and head turning, when experiencing asphyxia.
B) Infants in the side-lying position are vulnerable because the brainstem abnormality compromises their protective reflexes, such as arousal and head turning, when experiencing asphyxia.
C) Significant stressors contributing to SIDS include loose bedding.
D) Significant stressors contributing to SIDS include bed sharing.
E) Supine sleeping is a method to decrease the risk for SIDS.
Page Ref: 1157
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Summarize the risk factors for SIDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

11) The student nurse attends a workshop on culture and diversity with regard to sudden infant death syndrome (SIDS) and is now aware that the rate of occurrence is highest among which group of infants?
A) American Indians
B) Whites
C) Asians
D) Hispanics
Answer: A
Explanation: A) Rates of SIDS are highest for American Indians and Alaska Natives.
B) Rates of SIDS are not highest for Whites.
C) Rates of SIDS are lowest for Asians.
D) Rates of SIDS are lowest for Hispanics.
Page Ref: 1156
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Summarize the risk factors for SIDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

12) The nurse is planning care for the parents of an infant who died as the result of sudden infant death syndrome. Which collaborative interventions does the nurse plan when providing care to these parents? **Select all that apply.**

A) A psychosocial assessment
B) A grief counselor referral
C) A psychotherapist referral
D) A visit from the chaplain
E) A respiratory therapist referral

Answer: A, B, C, D

Explanation: A) The parents' grief will be acute, and they should receive a psychosocial assessment at each healthcare interaction.
B) Collaborative care for the parents may include grief counselors.
C) Collaborative care for the parents may include psychotherapists.
D) Collaborative care for the parents may include chaplains and religious leaders.
E) A respiratory therapist referral is inappropriate for this situation.

Page Ref: 1158
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of a family experiencing SIDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

13) The nurse is preparing to educate a group of parents on sudden infant death syndrome (SIDS). Which intervention is appropriate to decrease an infant's risk for SIDS?
A) Using firm bedding
B) Ensuring the room temperature is at least 80°F at all times
C) Recommending bed sharing
D) Placing the infant in a prone position for sleeping
Answer: A
Explanation: A) Using firm bedding is an appropriate intervention to decrease the risk of SIDS.
B) A specific room temperature is not identified to reduce the risk for SIDS.
C) Bed sharing should be discouraged and avoided to reduce the risk for SIDS.
D) The prone position should be avoided and discouraged to reduce the risk for SIDS.
Page Ref: 1158
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Summarize the risk factors for SIDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

14) At which time would sudden infant death syndrome (SIDS) be diagnosed?

A) When an autopsy reveals a brainstem defect
B) When an infant dies after being shaken violently
C) When an autopsy fails to find a cause of death
D) When an infant is found dead in their crib
Answer: C
Explanation: A) Although a brainstem defect related to respiratory and autonomic responses must be present, this is not usually found through autopsy.
B) Infants who die after being shaken violently have shaken baby syndrome, not SIDS.
C) SIDS is only diagnosed after a review of the child's clinical history, an examination of the scene of death, and an autopsy that fails to find a cause of death.
D) An infant found dead in their crib may have died from other causes rather than SIDS.
Page Ref: 1156
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Describe the pathophysiology of SIDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

15) In which way does a brainstem abnormality contribute to the risk of SIDS when an infant is placed on his stomach to sleep?
A) It decreases the infant's arousal and head turning responses during times of asphyxia.
B) It decreases the infant's respiratory drive during NREM sleep.
C) It increases periods of apnea, resulting in hypoxia and unconsciousness.
D) It increases the risk of aspiration and airway obstruction.
Answer: A
Explanation: A) A brainstem abnormality, when combined with a stressor such as sleeping in the prone position in a child in the first 6 months of life, will often result in SIDS due to a decreased arousal and head turning response during times of asphyxia.
B) A brainstem abnormality does not decrease the respiratory drive during NREM sleep.
C) A brainstem abnormality does not increase periods of apnea.
D) A brainstem abnormality does not increase the risk of aspiration and airway obstruction.
Page Ref: 1156
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 15.F. Analyze sudden infant death syndrome (SIDS) as it relates to oxygenation. Describe the etiology of SIDS.
MNL LO: Demonstrate understanding of the concept of oxygenation in the care of a patient with sudden infant death syndrome.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 16 Perfusion

The Concept of Perfusion

1) A pregnant client in the third trimester of pregnancy asks why an extra heart sound has developed since the last examination. Which response by the nurse is appropriate?
A) "You will need to have an echocardiogram to determine the reason for the extra sound."
B) "You are likely experiencing heart failure due to the extra fluid that accumulates during this time in pregnancy."
C) "You have what is known as a ventricular gallop, and it can be a normal finding during this trimester of pregnancy."
D) "You have what is known as atrial gallop, and this is cause for concern."
Answer: C
Explanation: A) There is no need for an echocardiogram.
B) While the S_3 sound can be associated with heart failure, this is not the case during pregnancy.
C) The third heart sound (S_3) may be heard in pregnant females during the third trimester. It is heard after S_2 and is termed a *ventricular gallop*. When the atrioventricular (AV) valves open, blood flow into the ventricles may cause vibrations. These vibrations create the S_3 sound during diastole.
D) S_4, also known as an *atrial gallop,* can be present in healthy individuals; however, it is not associated with pregnancy.
Page Ref: 1168

Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.1. Analyze the physiology of perfusion in the body.
MNL LO: Analyze the concept of perfusion and its application to nursing care.

2) The nurse is concerned that a client with an alteration in perfusion is at risk for inadequate oxygenation. Which intervention should the nurse add to the client's plan of care?
A) Encouraging ambulation every 30 minutes
B) Instructing on deep breathing
C) Administering medications appropriate to increase heart rate
D) Positioning to increase blood return
Answer: B
Explanation: A) Encouraging ambulation every 30 minutes would negatively impact oxygenation. Periods of rest should occur between activities, and no activity should be too strenuous.
B) The client is at risk for inadequate oxygenation. The nurse should consider teaching the client the importance of deep breathing to increase the amount of oxygen in the body tissues.
C) The nurse should consider medications that would reduce instead of increase the heart rate.
D) The client should be in the high-Fowler position to improve oxygenation. Positions to increase blood flow to the heart include Trendelenburg, which would negatively impact oxygenation.
Page Ref: 1182
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.3. Outline the relationship between perfusion and other concepts.
MNL LO: Analyze the concept of perfusion and its application to nursing care.

3) An older adult client is diagnosed with cardiomyopathy and a cardiac dysrhythmia. Which medication would the nurse expect to be prescribed for this client?
A) Beta blocker
B) Digoxin
C) Nitrate medications
D) Fluids
Answer: A
Explanation: A) Treatment for cardiomyopathy includes calcium channel blockers, beta blockers, and antiarrhythmics.
B) Digoxin should be avoided because it increases the force of contractions.
C) Nitrates should be avoided because they increase blood pressure.
D) The client should be on a sodium and fluid restriction and not be encouraged to drink fluids.
Page Ref: 1179
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.2. Differentiate alterations in perfusion.
MNL LO: Analyze the concept of perfusion and its application to nursing care.

4) The nurse is instructing a client on lifestyle changes to promote a healthy cardiovascular system. Which information should be included in this teaching session? **Select all that apply.**
A) Limit exercise to 15 minutes a day
B) Reduce saturated fats in the diet
C) Avoid cigarette smoking
D) Wear elastic hose
E) Limit fluid intake
Answer: B, C
Explanation: A) Clients should exercise for at least 30 minutes most days of the week to maintain a healthy cardiovascular system.
B) Interventions that help promote a healthy cardiovascular system include reducing saturated fats in the diet.
C) Interventions that would help promote a healthy cardiovascular system include avoiding cigarette smoking.
D) Wearing elastic hose is not known to contribute to a healthy cardiovascular system.
E) Limiting fluid intake is not known to contribute to a healthy cardiovascular system.
Page Ref: 1183
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Implementation
Learning Outcome: 16.4. Explain the promotion of healthy perfusion.
MNL LO: Analyze the concept of perfusion and its application to nursing care.

5) The nurse is preparing to conduct a cardiac assessment for a pediatric client. Which location will the nurse use when auscultating the apical pulse?
A) At the fifth intercostal space
B) At the left nipple
C) At the right nipple
D) At the eighth intercostal space
Answer: B
Explanation: A) The apical pulse is not auscultated at the fifth intercostal space in a pediatric client.
B) When assessing a pediatric client, it may be more beneficial to auscultate the apical pulse in the area of the left nipple at the fourth intercostal space.
C) The apical pulse is not auscultated at the right nipple in a pediatric client.
D) The apical pulse is not auscultated at the eighth intercostal space in a pediatric client.
Page Ref: 1187
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.8. Differentiate considerations related to the assessment and care of patients with alterations in perfusion throughout the lifespan.
MNL LO: Analyze the concept of perfusion and its application to nursing care.

6) The nurse is caring for a client who is scheduled to receive metoprolol (Lopressor). Which information should the nurse teach the client about this medication?
A) Expect a rapid heart rate.
B) Change positions slowly.
C) Reduce protein intake.
D) Increase fluids.
Answer: B
Explanation: A) This medication does not cause a rapid heart rate.
B) Metoprolol is a beta blocker. The client should be instructed to use care when ambulating and to change positions slowly because this medication causes orthostatic hypotension.
C) Protein restriction is not indicated with this medication.
D) The client should not be instructed to increase fluids.
Page Ref: 1202
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Implementation
Learning Outcome: 16.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in perfusion.
MNL LO: Analyze the concept of perfusion and its application to nursing care.

7) Which statements are correct regarding the various layers of the heart? **Select all that apply.**
A) The endocardium covers the entire heart and great vessels.
B) The endocardium is the muscular layer of the heart that contracts during each heartbeat.
C) The outermost layer of the heart is the epicardium.
D) The myocardium consists of myofibril cells.
E) The myocardium has four layers.
Answer: C, D
Explanation: A) The endocardium, which is the innermost layer, is a thin membrane composed of three layers.
B) The myocardium is the muscular layer of the heart that contracts during each heartbeat.
C) The outermost layer of the heart is the epicardium.
D) The myocardium, the middle layer of the heart wall, consists of specialized cardiac muscle cells (myofibrils).
E) The myocardium, the middle layer of the heart wall, consists of specialized cardiac muscle cells (myofibrils).
Page Ref: 1167
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.1. Analyze the physiology of perfusion in the body.
MNL LO: Analyze the concept of perfusion and its application to nursing care.

8) A client's stroke volume (SV) is 85mL/beat and the heart rate (HR) is 71 beats per minute (bpm). What is the client's cardiac output (CO) rounded to the nearest liter?
Answer: 6 Liters (L)
Explanation: $CO = SV \times HR$
$85mL = 0.085\ L$
$CO = 0.085 \times 71 = 6.035 = 6\ L$
Page Ref: 1171
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise, and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.1. Analyze the physiology of perfusion in the body.
MNL LO: Analyze the concept of perfusion and its application to nursing care.

9) Which factor is least likely to influence blood pressure?
A) Pumping action of the heart
B) Peripheral vascular resistance
C) Heart rate
D) Blood volume
Answer: C
Explanation: A) The factors that determine blood pressure include the pumping action of the heart.
B) The factors that determine blood pressure include the peripheral vascular resistance.
C) Heart rate by itself does not determine blood pressure.
D) The factors that determine blood pressure include blood volume and viscosity.
Page Ref: 1175
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.1. Analyze the physiology of perfusion in the body.
MNL LO: Analyze the concept of perfusion and its application to nursing care.

10) Which nursing intervention related to perfusion can be performed independently?
A) Administration of drug regimens
B) Insertion of device to measure central venous pressure (CVP)
C) Teaching relaxation techniques
D) Thoracentesis

Answer: C
Explanation: A) The nurse must administer drug regimens only under the order of a physician or nurse practitioner.
B) Although nurses can monitor central venous pressure, they are not responsible for inserting the device to measure CVP.
C) The nurse can teach relaxation techniques as an independent intervention to provide psychosocial support to the client.
D) A physician or nurse practitioner usually performs a thoracentesis.
Page Ref: 1196-1197
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.6. Analyze independent interventions nurses can implement for patients with alterations in perfusion.
MNL LO: Analyze the concept of perfusion and its application to nursing care.

11) The nurse is reviewing objective data obtained during the assessment of a pregnant woman in her 34th week of gestation. Which finding would be cause for concern?
A) Pulse 103 bpm
B) Blood pressure 108/70
C) Hematocrit 24%
D) WBC count 10,340/mm^3
Answer: C
Explanation: A) The pulse normally increases by 10-15 bpm during pregnancy.
B) During pregnancy, blood pressure decreases slightly.
C) During pregnancy, red blood cell (RBC) production and plasma volume increase, but because plasma volume increases more than RBC volume, the hematocrit decreases slightly. However, this client is experiencing a significant decrease in hematocrit, indicating insufficient production of RBCs.
D) During pregnancy, WBC count increases.
Page Ref: 1207
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.8. Differentiate considerations related to the assessment and care of patients with alterations in perfusion throughout the lifespan.
MNL LO: Analyze the concept of perfusion and its application to nursing care.

WwW.TeSm.Ws

Exemplar 16.A Cardiomyopathy

1) The nurse is caring for a client diagnosed with dilated cardiomyopathy. Which clinical manifestations does the nurse anticipate during the physical assessment? **Select all that apply.**
A) Fatigue
B) Lower extremity edema
C) Syncope
D) Dyspnea
E) Angina
Answer: A, B, D
Explanation: A) Clinical manifestations of dilated cardiomyopathy include fatigue.
B) Clinical manifestations of dilated cardiomyopathy include peripheral edema.
C) Syncope is commonly associated with hypertrophic cardiomyopathy and other forms of cardiomyopathy, but not with dilated cardiomyopathy.
D) Clinical manifestations of dilated cardiomyopathy include dyspnea.
E) Angina is commonly associated with hypertrophic cardiomyopathy and other forms of cardiomyopathy, but not with dilated cardiomyopathy.
Page Ref: 1212
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.A. Analyze cardiomyopathy as it relates to perfusion. Identify the clinical manifestations of cardiomyopathy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with cardiomyopathy.

2) A client states to the nurse, "I know I have high blood pressure, but I don't want to take medication." Based on this data, which health problem is the client at risk for developing?
A) Gastritis
B) Diabetes
C) Cardiomyopathy
D) Metabolic syndrome
Answer: C
Explanation: A) Hypertension has not been associated with gastritis.
B) Hypertension has not been associated with diabetes.
C) Hypertension places the client at risk for development of cardiomyopathy.
D) Hypertension has not been associated with metabolic syndrome.
Page Ref: 1212
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.5. Examine common barriers to active involvement of clients in their own healthcare processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment
Learning Outcome: 16.A. Analyze cardiomyopathy as it relates to perfusion. Compare the risk factors and prevention of cardiomyopathy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with cardiomyopathy.

3) A client diagnosed with cardiomyopathy reports having to rest between activities during the day. The client asks the nurse why this is occurring. Which reason should the nurse include in the response to the client?

A) Increased stroke volume
B) Decreased cardiac output
C) An elongated and dilated aorta
D) Increased blood pressure

Answer: B

Explanation: A) It is unknown if the client has increased stroke volume.

B) Decreased cardiac output is a result of decreased efficiency and contractibility of the myocardium. Rest could be required after each activity that puts physiological stress on the heart. Less blood is pumped from the heart to the rest of the body with a decreased cardiac output, and this has a direct effect on the activity level that can be tolerated.

C) It is unknown if the client has an elongated and dilated aorta.

D) It is unknown if the client has high blood pressure.

Page Ref: 1216

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation

Learning Outcome: 16.A. Analyze cardiomyopathy as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with cardiomyopathy.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with cardiomyopathy.

4) A client admitted with the diagnosis of cardiomyopathy becomes short of breath with ambulation and eating and fatigued with routine care activities. For which problem will the nurse plan this client's care?
A) Fluid volume excess
B) Lack of knowledge of disease process
C) Inability to tolerate activity
D) Inability to care for self
Answer: C
Explanation: A) There is not enough information to determine if the client has an excess in fluid volume.
B) There is not enough information to determine if the client lacks knowledge of the disease process.
C) The client is short of breath with ambulation and eating and fatigued with routine care activities. The problem of inability to tolerate activity applies to the client at this time.
D) There is not enough information to determine if the client is unable to care for self.
Page Ref: 1216
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.B.1. Elicit client values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Diagnosis
Learning Outcome: 16.A. Analyze cardiomyopathy as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with cardiomyopathy.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with cardiomyopathy.

5) The nurse identifies the problem of imbalanced fluid volume as appropriate for a client with cardiomyopathy. Which interventions should the nurse emphasize when planning this client's care? **Select all that apply.**

A) Monitor B-type natriuretic peptide (BNP) level.
B) Provide oxygen as prescribed.
C) Assess respiratory status and lung sounds every 4 hours and as needed.
D) Provide information about activity upon discharge.
E) Monitor intake and output.

Answer: C, E

Explanation: A) Monitoring BNP level is appropriate for the problem of altered cardiac output.
B) Providing oxygen is appropriate for the problem with altered oxygenation.
C) Interventions appropriate for the problem of excess fluid include assessing respiratory status and lung sounds every 4 hours and as needed.
D) Providing information about activity upon discharge would be appropriate for the problem about activity.
E) Interventions appropriate for the problem of excess fluid include monitoring intake and output.

Page Ref: 1216-1217
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.A. Analyze cardiomyopathy as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with cardiomyopathy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with cardiomyopathy.

6) The nurse is providing teaching to a client diagnosed with cardiomyopathy. Which statement made by the client indicates the discharge teaching was effective?
A) "I will exercise as much as possible, regardless of feeling weak and short of breath."
B) "My pants getting tight around the waist means I'm eating too much and should cut back on food."
C) "I will eat foods containing sodium only if drinking water with them."
D) "I will see my cardiologist next week to discuss implanting a pacemaker."
Answer: D
Explanation: A) Exercise when feeling weak and short of breath indicates the client needs additional instruction and follow-up.
B) Snug pants around the waist indicates the client needs more teaching.
C) Eating foods with sodium and drinking water indicates the client needs more teaching.
D) Pacemakers are needed in some clients with cardiomyopathy to prevent sudden cardiac death. The client should discuss the need for a pacemaker with his cardiologist.
Page Ref: 1214
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Evaluation

Learning Outcome: 16.A. Analyze cardiomyopathy as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with cardiomyopathy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with cardiomyopathy.

7) The nurse is caring for a client with hypertrophic cardiomyopathy. Based on this diagnosis, which class of medications does the nurse anticipate being prescribed?
A) Digoxin
B) Vasodilators
C) Nitrates
D) Beta blockers
Answer: D
Explanation: A) Digoxin is contraindicated for the client with hypertrophic cardiomyopathy.
B) Vasodilators are not used to treat hypertrophic cardiomyopathy.
C) Nitrates are not used to treat hypertrophic cardiomyopathy.
D) Beta blockers may be prescribed to relax the heart, stabilize the rhythm, and slow the heart's pumping action in clients with hypertrophic cardiomyopathy.
Page Ref: 1214
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 16.A. Analyze cardiomyopathy as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with cardiomyopathy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with cardiomyopathy.

8) A client with cardiomyopathy receiving diuretic therapy has a urine output of 200 mL in 8 hours. Which action by the nurse is correct?
A) Assist the client to ambulate.
B) Document a normal urine output.
C) Notify the healthcare provider.
D) Measure abdominal girth.
Answer: C
Explanation: A) The nurse should not assist the client out of bed to ambulate at this time.
B) This is not a normal urine output.
C) The nurse should notify the healthcare provider, because a urine output of 200 mL in 8 hours is less than 30 mL per hour. The client could be dehydrated despite having peripheral edema.
D) Abdominal girth is not an objective measurement of fluid volume; daily weight is more precise.
Page Ref: 1217
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2 Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.A. Analyze cardiomyopathy as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with cardiomyopathy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with cardiomyopathy.

9) A client diagnosed with cardiomyopathy asks the nurse to explain the different types of the disease. Which is inappropriate for the nurse to include in the teaching session?
A) Dilated cardiomyopathy
B) Restrictive cardiomyopathy
C) Hypotrophic cardiomyopathy
D) Arrythmogenic right ventricular dysplasia
Answer: C
Explanation: A) Dilated is a type of cardiomyopathy.
B) Restrictive is a type of cardiomyopathy.
C) Hypotrophic is not a type of cardiomyopathy.
D) Arrhythmogenic is a type of cardiomyopathy.
Page Ref: 1211
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.A. Analyze cardiomyopathy as it relates to perfusion. Describe the pathophysiology of cardiomyopathy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with cardiomyopathy.

10) A client with cardiomyopathy is having tachycardia. Which medication does the nurse anticipate being prescribed?
A) ACE Inhibitor
B) Angiotensin II receptor blocker
C) Beta blocker
D) Cardiac glycoside
Answer: C
Explanation: A) ACE inhibitors are used to decrease blood pressure in a client with cardiomyopathy.
B) Angiotensin II receptor blockers are used to decrease blood pressure in a client with cardiomyopathy.
C) A client with cardiomyopathy experiencing tachycardia may take a beta blocker to lower the heart rate.
D) Cardiac glycosides are used in congestive heart failure and do not assist in lowering the heart rate in a client with cardiomyopathy.
Page Ref: 1212
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.A. Analyze cardiomyopathy as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with cardiomyopathy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with cardiomyopathy.

11) The nurse is caring for a client with cardiomyopathy who is experiencing activity intolerance. Which intervention is inappropriate for this problem?
A) Spacing out nursing activities so client fatigue is lessened
B) Assisting with client activities of daily living (ADLs) as necessary
C) Using passive and active range-of-motion (ROM) exercises as tolerated
D) Consulting with a physical therapist on an activity plan
Answer: A
Explanation: A) The nurse should cluster nursing activities, not space them out, in order to conserve client energy. This allows the client to rest between periods of nursing care.
B) The client who is experiencing activity intolerance should have assistance with ADLs.
C) The client who is experiencing activity intolerance should have ROM exercises.
D) The client who is experiencing activity intolerance should receive a physical therapy consult.
Page Ref: 1217
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.A. Analyze cardiomyopathy as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with cardiomyopathy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with cardiomyopathy.

12) The nurse is educating a client with cardiomyopathy about diet choices that are appropriate for the client's condition. Which statement is inappropriate for the nurse to include in the teaching session?
A) "It is important to monitor your sodium intake."
B) "Increasing your dietary protein helps with cardiac cell repair."
C) "Here is a list of high-fat, high-cholesterol foods to avoid."
D) "I have notified the dietitian regarding your condition in order to provide you with more information."
Answer: B
Explanation: A) The nurse should instruct the client with cardiomyopathy to monitor sodium intake.
B) Instructing the client to increase protein is not appropriate and is not shown effective in managing cardiomyopathy.
C) The nurse should instruct the client with cardiomyopathy to avoid high-fat, high-cholesterol food.
D) Consulting with the dietitian is appropriate with this client.
Page Ref: 1217
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.A. Analyze cardiomyopathy as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with cardiomyopathy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with cardiomyopathy.

13) A 14-year-old child was recently diagnosed with hypertrophic cardiomyopathy. During a follow-up appointment, the mother asks the nurse, "How will this affect my child's ability to play football in the fall?" In which way should the nurse respond?
A) "This shouldn't affect his ability to play football."
B) "Children with cardiomyopathy should not play football."
C) "He could participate in flag football but not tackle football."
D) "This may actually make him a better, stronger football player."
Answer: B
Explanation: A) The child should not play football.
B) Children with cardiomyopathy should not play competitive sports due to the possibility of collapse or increased heart failure.
C) Depending on the child's clinical status, low-impact activities may be appropriate, but this should be discussed with the child's physician.
D) The child will not be better or stronger if playing football.
Page Ref: 1215
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.A. Analyze cardiomyopathy as it relates to perfusion. Differentiate care of patients with cardiomyopathy across the lifespan.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with cardiomyopathy.

14) A 72-year-old client diagnosed with hypertrophic cardiomyopathy (HCM) is speaking to the healthcare team about treatment options. Which treatment option would least likely be recommended for this client, even though it is commonly used to treat younger clients with this condition?
A) Defibrillator implantation
B) Beta-blocker administration
C) Calcium channel blocker administration
D) Physical activity restrictions
Answer: A
Explanation: A) The low morbidity and mortality rates among older clients do not support the use of the defibrillator devices frequently implanted in younger clients.
B) Treatment guidelines for older clients with HCM may include the use of beta blockers.
C) Treatment guidelines for older clients with HCM may include calcium channel blockers.
D) Treatment guidelines for older clients with HCM may include restrictions on physical activity.
Page Ref: 1215
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.A. Analyze cardiomyopathy as it relates to perfusion. Differentiate care of patients with cardiomyopathy across the lifespan.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with cardiomyopathy.

Exemplar 16.B Congenital Heart Defects

1) The mother of a baby born with a congenital heart defect is upset, as no one else in the family has been born with this condition. To determine the cause of the defect, which question is appropriate for the nurse to ask the mother?
A) "Did you consume any alcohol before you knew you were pregnant?"
B) "Is there a history of diabetes in your family?"
C) "Was the baby's father exposed to any toxins in the work environment?"
D) "Do you have a history of hypertension?"
Answer: A
Explanation: A) Most congenital heart defects occur during the first 8 weeks of pregnancy and are a combination of environmental and genetic factors. Fetal exposure to alcohol is one of the greatest factors for the development of these defects. Asking the mother if she consumed alcohol before she was aware that she was pregnant is an appropriate question when determining the cause of the heart defect.
B) Maternal diabetes can impair fetal heart development, but a family history of diabetes is not known to cause congenital heart defects.
C) The father's exposure to toxins in the work environment is not known to cause congenital heart defects in children.
D) A history of hypertension will not cause a fetus to develop a congenital heart defect.
Page Ref: 1226
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.B. Analyze congenital heart defects as they relate to perfusion. Compare the risk factors and prevention of congenital heart defects.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with congenital heart defects.

2) The nurse is analyzing data collected after assessing a child with a congenital heart defect that decreases pulmonary blood flow. Which problem would be applicable for this client?
A) Pain
B) Problems breathing
C) Decreased cardiac output
D) Overabundance of body fluid
Answer: C
Explanation: A) Pain is an appropriate problem for a child following cardiac surgery.
B) Problems breathing is a problem for a child following cardiac surgery.
C) A problem for a client with congenital heart defects that decrease pulmonary blood flow include decreased cardiac output.
D) Overabundance of body fluid is a problem in a client with a congenital heart defect that increases pulmonary blood flow.
Page Ref: 1234
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Diagnosis
Learning Outcome: 16.B. Analyze congenital heart defects as they relate to perfusion. Apply the nursing process in providing culturally competent care to an individual with congenital heart defects.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with congenital heart defects.

3) The nurse is planning care for a pediatric client recovering from surgery to repair a congenital heart defect. Which intervention should the nurse include to support the client's fluid status?
A) Encourage oral intake of fluids when permitted.
B) Limit oral and intravenous intake of fluids.
C) Continue normal saline administration even after oral intake is normal.
D) Convert the intravenous line to a saline lock immediately after surgery.
Answer: A
Explanation: A) The child should be encouraged to begin oral fluids and nutrition when permitted.
B) Although oral fluids are rarely limited, intake and output should be carefully assessed.
C) Fluids and antibiotics should be provided as ordered until the child's oral intake is normal.
D) Once normal, the line can be converted to a heparin or saline lock.
Page Ref: 1235
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.B. Analyze congenital heart defects as they relate to perfusion. Apply the nursing process in providing culturally competent care to an individual with congenital heart defects.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with congenital heart defects.

4) The nurse provides discharge instructions to the parents of a child recovering from surgery to repair a congenital heart defect. Which statement indicates that teaching has been effective?
A) "Our child should be restricted in play and activity for at least 6 months."
B) "Our child will need to take antibiotics prior to having dental surgery."
C) "Fluids should be restricted to maximize lung function."
D) "Our child should not return to normal activities for at least 2 years."
Answer: B
Explanation: A) The child should be encouraged to gradually return to normal activities, including play.
B) Since the child is at risk for infective endocarditis, prophylactic antibiotics are indicated for invasive procedures.
C) The child should not restrict fluids.
D) The child's activity should not be restricted for 6 months to 2 years.
Page Ref: 1236
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Evaluation
Learning Outcome: 16.B. Analyze congenital heart defects as they relate to perfusion. Apply the nursing process in providing culturally competent care to an individual with congenital heart defects.

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MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with congenital heart defects.

5) The nurse is caring for a premature infant diagnosed with patent ductus arteriosus (PDA). Which medication should the nurse anticipate administering to this client?

A) Indomethacin

B) Propranolol

C) Antibiotics

D) Prostaglandin E_1

Answer: A

Explanation: A) Intravenous indomethacin often stimulates the closure of the PDA in premature infants.

B) Propranolol is used to treat tetralogy of Fallot.

C) Prophylactic antibiotics are used in some clients with a congenital heart defect, but this is not common for infants with PDA.

D) Prostaglandin E_1 is used with some congenital heart defects to maintain a PDA, not help close the PDA.

Page Ref: 1219

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning

Learning Outcome: 16.B. Analyze congenital heart defects as they relate to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a congenital heart defect.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with congenital heart defects.

6) A baby will be having surgery to correct a congenital heart defect. On which topic should the parents be instructed regarding the care of the child before surgery?
A) Restricting immunizations until after the surgery
B) Preventing exposure to infection
C) Implementing no particular precautions
D) Restricting fluids for a week before the surgery
Answer: B
Explanation: A) Immunizations should be continued.
B) Preoperative care of a baby having surgery to correct a congenital heart defect should include prevention from infection with good hand washing.
C) There are precautions that the parents should take to ensure the child is in optimal health prior to the surgery.
D) The parents may be instructed to withhold food and fluids several hours before the surgery. Fluids would not be restricted for a week before surgery.
Page Ref: 1234
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.B. Analyze congenital heart defects as they relate to perfusion. Apply the nursing process in providing culturally competent care to an individual with congenital heart defects.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with congenital heart defects.

7) The nurse is assessing a toddler diagnosed with tetralogy of Fallot (TOF). Which clinical manifestations does the nurse anticipate during the physical assessment? **Select all that apply.**
A) Palpable thrill in the pulmonic area
B) Nail clubbing
C) Cough
D) Apneic periods
E) Knee-chest position
Answer: A, B, E
Explanation: A) Manifestations of TOF include a palpable thrill in the pulmonic area.
B) Manifestations of TOF include clubbing of the fingers due to reduce oxygenation.
C) A cough is not a manifestation of this congenital heart defect.
D) Apneic periods are not manifestations of this congenital heart defect.
E) Manifestations of TOF include the knee-chest position, which the child will perform to decrease the return of systemic venous blood to the heart.
Page Ref: 1223
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.B. Analyze congenital heart defects as they relate to perfusion. Identify the clinical manifestations of congenital heart defects.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with congenital heart defects.

8) Which best describes how congenital defects are categorized?
A) By the severity of defect
B) By the pathophysiology and hemodynamics of defect
C) By the location of defect
D) By the infant's age when the defect was diagnosed
Answer: B
Explanation: A) Congenital heart defects are not categorized by the severity of the defect.
B) Congenital heart defects are categorized by their pathophysiology and hemodynamics.
C) Congenital heart defects are not categorized by the location of the defect.
D) Congenital heart defects are not categorized by the infant's age when the defect is diagnosed.
Page Ref: 1218
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.B. Analyze congenital heart defects as they relate to perfusion. Describe the pathophysiology of congenital heart defects.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with congenital heart defects.

9) The nurse is caring for a child with an atrial septal defect (ASD). Which manifestations would the nurse expect upon assessment? **Select all that apply.**

A) Pulmonary artery hypotension
B) Midsystolic murmur at lower right sternal border
C) Mitral valve regurgitation with cleft on mitral valve
D) S_1 heart tone may be split due to forceful left ventricular contraction
E) Congestive heart failure

Answer: C, E

Explanation: A) Pulmonary artery hypertension is seen in ASD.
B) The midsystolic murmur can be heard at the lower left sternal border.
C) Mitral valve regurgitation may occur with a cleft on the mitral valve.
D) S_1 heart tones may be split due to forceful right ventricular contraction.
E) Congestive heart failure may occur.

Page Ref: 1219

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment

Learning Outcome: 16.B. Analyze congenital heart defects as they relate to perfusion. Identify the clinical manifestations of congenital heart defects.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with congenital heart defects.

10) The nurse is providing teaching to the parents of a child born with tetralogy of Fallot (TOF). Which statement should the nurse include in her teaching regarding this defect?

A) "Increased pulmonary blood flow causes symptoms with this disease."

B) "This disease consists of pulmonic stenosis, left ventricular hypertrophy, ventricular septal defect, and an overriding aorta."

C) "Your child has a decreased amount of red blood cells because of this disease."

D) "This disease consists of pulmonic stenosis, right ventricular hypertrophy, ventricular septal defect, and an overriding aorta."

Answer: D

Explanation: A) TOF is characterized by decreased pulmonary blood flow.

B) TOF consists of four defects–pulmonic stenosis, right ventricular hypertrophy, ventricular septal defect, and an overriding aorta.

C) TOF is characterized by polycythemia (increased red blood cells due to hypoxia).

D) TOF consists of four defects–pulmonic stenosis, right ventricular hypertrophy, ventricular septal defect, and an overriding aorta.

Page Ref: 1222

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation

Learning Outcome: 16.B. Analyze congenital heart defects as they relate to perfusion. Identify the clinical manifestations of congenital heart defects.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with congenital heart defects.

11) The nurse is caring for an infant diagnosed with hypoplastic left heart syndrome. The client has recently been scheduled for surgery to repair the defect. Which procedure does the nurse anticipate needing to provide client teaching about to the client's family?
A) Norwood procedure
B) Jatene procedure
C) Rastelli procedure
D) Damus-Kaye-Stansel procedure
Answer: A
Explanation: A) Hypoplastic left heart syndrome is repaired using the Norwood, Glenn, and Fontan procedures, depending on the child's age.
B) The Jatene procedure surgically repairs the Transposition of Great Arteries (TGA).
C) The Rastelli procedure is used to repair TGA with ventricular septal defect and pulmonary stenosis.
D) The Damus-Kaye-Stansel procedure surgically repairs the Transposition of Great Arteries (TGA).
Page Ref: 1225
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.B. Analyze congenital heart defects as they relate to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a congenital heart defect.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with congenital heart defects.

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12) During what period of gestation do congenital heart defects usually develop?
A) First 8 weeks of gestation
B) Second trimester
C) Third trimester
D) Last 4 weeks of gestation
Answer: A
Explanation: A) Most congenital heart defects develop during the first 8 weeks of gestation.
B) Most congenital heart defects do not develop during the second trimester.
C) Most congenital heart defects do not develop during the third trimester.
D) Most congenital heart defects do not develop during the last 4 weeks of gestation.
Page Ref: 1223
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.B. Analyze congenital heart defects as they relate to perfusion. Describe the etiology of congenital heart defects.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with congenital heart defects.

13) The nurse is caring for a pregnant woman with congenital heart disease. The woman asks if she will be able to have a vaginal delivery. Which answer by the nurse is correct?
A) A cesarean section is preferred because you will lose less blood than with a vaginal birth.
B) A cesarean section is preferred because there is a lower risk of infection than with a vaginal birth.
C) A vaginal birth is preferred over a cesarean section for women who have aortic stenosis.
D) A vaginal birth is preferred because there is a lower risk of thrombophlebitis than with a Cesarean section.
Answer: A
Explanation: A) Vaginal delivery is preferable to cesarean section for most clients with congenital heart defects because they will likely lose less blood with vaginal birth.
B) Risk of wound infection is a concern with cesarean birth.
C) A vaginal delivery is contraindicated in aortic stenosis.
D) Thrombophlebitis is a concern with cesarean birth.
Page Ref: 1232
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.B. Analyze congenital heart defects as they relate to perfusion. Differentiate care of patients with congenital heart defects across the lifespan.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with congenital heart defects.

14) The nurse is caring for an adult client who was diagnosed with a congenital heart defect as a child, which was later repaired with surgery. Which common complication of a heart defect should the nurse monitor that the client may still be at risk for?
A) Deep vein thrombosis
B) Endocarditis
C) Atherosclerosis
D) Shock
Answer: B
Explanation: A) Congenital heart defects do not normally cause deep vein thrombosis.
B) Common complications of congenital heart defects that develop during adulthood include dysrhythmias, endocarditis, stroke, heart failure, pulmonary hypertension, and heart valve problems.
C) Congenital heart defects do not normally cause atherosclerosis.
D) Congenital heart defects do not normally cause shock.
Page Ref: 1232
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.B. Analyze congenital heart defects as they relate to perfusion. Differentiate care of patients with congenital heart defects across the lifespan.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with congenital heart defects.

Exemplar 16.C Coronary Artery Disease

1) The nurse is documenting assessment findings on a client with angina. Which term should the nurse use to describe chest pain that occurs at night and is unrelated to activity?
A) Nonanginal pain
B) Prinzmetal angina
C) Unstable angina
D) Stable angina
Answer: B
Explanation: A) The client has been diagnosed with angina, and, therefore, the chest pain the client is experiencing is likely angina, not non-anginal pain.
B) Prinzmetal (variant) angina is unrelated to activity and often occurs at night.
C) Unstable angina occurs with increasing frequency, severity, and duration. The pain is unpredictable.
D) Stable angina is induced by exercise and is relieved by rest or nitroglycerin.
Page Ref: 1240
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.C. Analyze coronary artery disease (CAD) as it relates to perfusion. Describe the pathophysiology of CAD.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with coronary artery disease.

2) The nurse is caring for a client who has had a myocardial infarction. The client states, "I have been smoking for 35 years, what good will quitting do?" Which response is best?
A) "Your risk of continued coronary artery disease will decrease by half when you stop."
B) "Quitting will enhance the effects of your medications."
C) "Your medications will not work if you smoke."
D) "Quitting will ensure you don't develop any complications."
Answer: A
Explanation: A) Smoking cessation reduces the risk for coronary heart disease by 50% no matter how long the person has smoked.
B) Smoking cessation will possibly enhance medication effects, but the primary focus for this client is the effect on coronary artery disease.
C) Smoking cessation will possibly enhance medication effects.
D) Smoking cessation will reduce the possibility of complications, but the primary focus for this client is the effect on coronary artery disease.
Page Ref: 1244
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.C. Analyze coronary artery disease (CAD) as it relates to perfusion. Compare the risk factors and prevention of CAD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with coronary artery disease.

3) The nurse is preparing preoperative teaching for a client scheduled for a ventricular assist device (VAD). Which should the nurse include in these instructions?
A) Need to stay on bedrest for a week or more
B) Cardiac pain postoperatively is to be expected
C) Risk for postoperative infection
D) Expect to be ambulating the evening of surgery
Answer: C
Explanation: A) The client may or may not be on bedrest for a week or more after the surgery.
B) Cardiac pain postoperatively is not to be expected and could indicate a myocardial infarction.
C) Clients with VAD are at considerable risk for infection; strict aseptic technique is used with all invasive catheters and dressing changes.
D) The client will most likely not be ambulating the evening of the surgery.
Page Ref: 1258
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.C. Analyze coronary artery disease (CAD) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with CAD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with coronary artery disease.

4) The nurse is instructing an older adult client about atorvastatin (Lipitor) to treat elevated cholesterol. Which side effects should the nurse advise the client to report to the healthcare provider?
A) Headaches and nausea
B) Muscle pain and weakness
C) Bruising and excessive bleeding
D) Shortness of breath and coughing
Answer: B
Explanation: A) Headaches are not common side effects that need to be reported to the physician.
B) Clients taking statins, such as atorvastatin (Lipitor), should promptly report muscle pain, tenderness, or weakness; skin rash, hives, or changes in skin color; and abdominal pain, nausea, or vomiting.
C) Bruising or bleeding are not common side effects that need to be reported to the physician.
D) Shortness of breath or coughing are not common side effects that need to be reported to the physician.
Page Ref: 1251
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2 Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.C. Analyze coronary artery disease (CAD) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with CAD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with coronary artery disease.

5) The nurse is providing care to a client who has experienced several episodes of angina. Which prescription does the nurse anticipate to reduce the intensity and frequency of an angina episode?
A) Therapeutic lifestyle changes
B) Statin therapy
C) Nitrate therapy
D) Anticoagulant therapy
Answer: C
Explanation: A) Therapeutic lifestyle changes are significant if the client is to maintain a healthy heart.
B) Statins are used to decrease cholesterol levels.
C) A primary goal in the treatment of angina is to reduce the intensity and frequency of angina episodes. Rapid-acting organic nitrates are the drugs of choice for terminating an acute angina episode.
D) Anticoagulant therapy is used to prevent additional thrombi from forming post-myocardial infarction.
Page Ref: 1240
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning

Learning Outcome: 16.C. Analyze coronary artery disease (CAD) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with CAD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with coronary artery disease.

6) A client recovering from an acute myocardial infarction is prescribed aspirin. Which teaching points should the nurse include regarding this prescription? **Select all that apply.**
A) Report any itching after seven days of taking.
B) Check with your healthcare provider before taking herbal remedies.
C) Take at a different time of day than warfarin.
D) Report bleeding or bruising to the healthcare provider.
E) Do not skip any scheduled appointments to have blood drawn for labs.
Answer: B, D
Explanation: A) Itching is not a common side effect of aspirin therapy.
B) Herbal remedies such as evening primrose oil, garlic, gingko biloba, or grapeseed extract can increase the effect of the aspirin.
C) Aspirin and Coumadin are not to be taken concurrently.
D) Bleeding and bruising can occur and should be reported to the healthcare provider.
E) Aspirin inhibits platelet aggregation and clot formation. No lab appointments will be made just for aspirin therapy.
Page Ref: 1255
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.C. Analyze coronary artery disease (CAD) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with CAD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with coronary artery disease.

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7) A client with angina is experiencing acute chest pain. The client rates the pain as a 7 out of 10. The client's vital signs include P 119, R 24, BP 98/63, T 99.1°F, and SpO_2 89%. Which actions would the nurse implement at this time? **Select all that apply.**
A) Administer antianxiety medication as prescribed.
B) Coach in nonpharmacologic pain management techniques.
C) Implement bedrest.
D) Administer morphine sulfate 2 mg intravenous push as prescribed.
E) Administer oxygen at 2 liters/minute via nasal cannula as prescribed.
Answer: C, D, E
Explanation: A) Antianxiety medications are not effective in acute chest pain.
B) Nonpharmacologic pain management techniques are not appropriate for an episode of acute chest pain.
C) Interventions for the client experiencing acute chest pain include keeping the client on bedrest.
D) Interventions for the client experiencing acute chest pain include administering morphine sulfate as prescribed.
E) Interventions for the client experiencing acute chest pain include administering oxygen as prescribed.
Page Ref: 60
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.C. Analyze coronary artery disease (CAD) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with CAD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with coronary artery disease.

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8) The nurse is teaching a client about the different types of angina. Which client statement indicates the need for follow up teaching?
A) "Stable angina is the most common form of angina."
B) "Prinzmetal angina is atypical angina that occurs with strenuous exercise."
C) "Unstable angina occurs with increasing frequency, severity, and duration."
D) "Clients with unstable angina are at risk for a heart attack."
Answer: B
Explanation: A) Stable angina is the most common form of angina and is relieved with rest and nitrate medications.
B) Prinzmetal angina is atypical angina that is unrelated to activity.
C) Unstable angina occurs with increasing frequency, severity, and duration.
D) Clients with unstable angina are at risk for a heart attack, or myocardial infarction.
Page Ref: 1240
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Evaluation
Learning Outcome: 16.C. Analyze coronary artery disease (CAD) as it relates to perfusion. Describe the pathophysiology of CAD.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with coronary artery disease.

9) The nurse is providing care to a female client who is diagnosed with coronary artery disease. The client states to the nurse, "I don't know how this happened." Which response by the nurse is the most appropriate?

A) "Women who take oral contraceptives are more likely to develop this disease."
B) "Women who have children later in life often develop this disease"
C) "Women with a history of sexually transmitted infections are more likely to develop this disease."
D) "Women who conceive through the use of in-vitro fertilization are more likely to develop this disease."

Answer: A

Explanation: A) Risk factors for coronary artery disease that are unique to women include premature menopause, oral contraceptive use, and hormone replacement therapy (HRT).
B) Having children later in life does not increase the risk of coronary artery disease for women.
C) A history of sexually transmitted infections does not increase the risk of coronary artery disease for women.
D) The use of in-vitro fertilization does not increase the risk of coronary artery disease for women.

Page Ref: 1244
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Implementation
Learning Outcome: 16.C. Analyze coronary artery disease (CAD) as it relates to perfusion. Differentiate care of patients with CAD across the lifespan.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with coronary artery disease.

10) The nurse is teaching a client about the associated health risks of cocaine use. Which statement should the nurse use to describe how cocaine can cause myocardial infarction (MI)?
A) Cocaine significantly increases the serum triglyceride level, leading to the development of an atheroma.
B) Cocaine alters the body's clotting mechanisms, leading to thrombus formation.
C) Cocaine increases sympathetic nervous system stimulation, increasing blood pressure and vasoconstriction.
D) Cocaine alters electrolyte balance, leading to arrhythmias.
Answer: C
Explanation: A) Cocaine does not increase serum triglyceride levels.
B) Cocaine does not alter the clotting mechanisms.
C) Acute MI may also develop as a result of cocaine intoxication. Cocaine increases sympathetic nervous system activity by both increasing the release of catecholamines from central and peripheral stores and interfering with the reuptake of catecholamines. This increased catecholamine concentration stimulates the heart rate and increases its contractility, increases the automaticity of cardiac tissues and the risk of dysrhythmias, and causes vasoconstriction and hypertension.
D) Cocaine does not alter electrolyte balance.
Page Ref: 1242
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.C. Analyze coronary artery disease (CAD) as it relates to perfusion. Describe the pathophysiology of CAD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with coronary artery disease.

11) A community health nurse is providing education to a group of adults regarding myocardial infarction (MI). When discussing ways to prevent the number of MI-related deaths, which statement by the nurse is inappropriate?
A) "It is important to learn how to perform cardiopulmonary resuscitation (CPR)."
B) "Be sure to take a baby aspirin every day to help prevent an MI."
C) "Increase your knowledge of the manifestations of MI."
D) "Seek immediate medical attention when you suspect an MI."
Answer: B
Explanation: A) Learning CPR is appropriate.
B) Instructing all clients to take a baby aspirin every day to help prevent an MI is inappropriate, as not all clients should take this medication.
C) Learning about the manifestations of MI is appropriate.
D) Clients should be taught to seek immediate medical attention when they suspect an MI.
Page Ref: 1259
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.C. Analyze coronary artery disease (CAD) as it relates to perfusion. Compare the risk factors and prevention of CAD.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with coronary artery disease.

12) Which finding is the most common clinical manifestation of coronary artery disease?
A) Chest pain
B) Dyspnea
C) Irritability
D) Tachycardia
Answer: A
Explanation: A) Coronary artery disease is often asymptomatic. When clinical manifestations do occur, the most common indications are angina and myocardial infarction. Angina, acute coronary syndrome, and acute myocardial infarction are all characterized by the presence of chest pain of various intensities.
B) Dyspnea may be present in some clients, chest pain is the classical manifestation of coronary artery disease.
C) Irritability may be present in some clients, chest pain is the classical manifestation of coronary artery disease.
D) Tachycardia may be present in some clients, chest pain is the classical manifestation of coronary artery disease.
Page Ref: 1245
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.C. Analyze coronary artery disease (CAD) as it relates to perfusion. Identify the clinical manifestations of CAD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with coronary artery disease.

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13) For a client with coronary artery disease, which action can the nurse recommend to the client to help decrease cardiac workload and sympathetic nervous system stimulation?
A) Physical rest
B) Psychological rest
C) Fluid intake
D) Fluid restriction
Answer: A
Explanation: A) For the client with coronary artery disease, physical rest helps decrease cardiac workload and sympathetic nervous system stimulation, promoting comfort.
B) Information and emotional support help decrease anxiety and promote psychological rest.
C) Fluid overload may increase cardiac workload.
D) The nurse should not restrict fluids unless prescribed by the physician.
Page Ref: 1255
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.C. Analyze coronary artery disease (CAD) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with CAD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with coronary artery disease.

14) The nurse is caring for a 76-year-old client with a history of angina. Which atypical age-related warning sign of a myocardial infarction should the nurse need to include in client teaching?
A) Cool, clammy skin
B) Chest pain
C) Tachycardia
D) Abdominal pain
Answer: D
Explanation: A) Cool, clammy skin is a symptom of myocardial infarction that is more common in younger individuals but less common in older individuals.
B) Chest pain is a symptom of myocardial infarction that is more common in younger individuals but less common in older individuals.
C) Tachycardia is a symptom of myocardial infarction that is more common in younger individuals but less common in older individuals.
D) Older adults commonly have atypical symptoms of myocardial infarction, such as difficulty breathing, confusion, fainting, dizziness, abdominal pain, or cough.
Page Ref: 1258
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation

Learning Outcome: 16.C. Analyze coronary artery disease (CAD) as it relates to perfusion. Differentiate care of patients with CAD across the lifespan.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with coronary artery disease.

Exemplar 16.D Deep Venous Thrombosis

1) The nurse is completing an assessment on a newly admitted client. Which finding would indicate to the nurse that the client may be experiencing a deep venous thrombosis (DVT)?
A) Shortness of breath after activity
B) Two-plus palpable pedal pulses
C) Swelling in one leg with edema
D) Sharp pain in both legs
Answer: C
Explanation: A) Shortness of breath that subsides after activity is not a manifestation of DVT.
B) Two-plus palpable pulses are not manifestations of DVT.
C) Manifestations of DVT include swelling in one leg with pitting edema because the clot is obstructing the venous return from the leg.
D) Pain in the affected extremity is usually dull and aching, not sharp.
Page Ref: 1266
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.D. Analyze deep venous thrombosis (DVT) as it relates to perfusion. Identify the clinical manifestations of DVT.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with deep vein thrombosis.

2) The nurse is planning care for a group of clients. Which client should the nurse identify as having the greatest risk for developing deep venous thrombosis (DVT)?
A) The client recovering from laparoscopic gallbladder surgery
B) The client admitted with new-onset type 2 diabetes
C) The client admitted with community-acquired pneumonia
D) The client recovering from knee replacement surgery
Answer: D
Explanation: A) The client recovering from laparoscopic gallbladder surgery would be at a lower risk for DVT because prolonged immobility will not occur.
B) The client admitted with new-onset type 2 diabetes would be at a lower risk for DVT because prolonged immobility will not occur.
C) The client admitted with community-acquired pneumonia would be at a lower risk for DVT because prolonged immobility will not occur.
D) Up to 80% of clients with an orthopedic procedure will develop a DVT if no prophylaxis is provided.
Page Ref: 1266
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.D. Analyze deep venous thrombosis (DVT) as it relates to perfusion. Compare the risk factors and prevention of DVT.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with deep vein thrombosis.

3) A client recovering from a cesarean section and breastfeeding is diagnosed with superficial venous thrombosis. Which intervention should the nurse anticipate carrying out first?
A) Encourage to ambulate freely
B) Aspirin 650 mg every 4 hours
C) Apply warm, moist compresses
D) Provide methylergonovine (Methergine) IM
Answer: C
Explanation: A) Ambulation would increase the inflammation.
B) Heparin or warfarin is preferred over aspirin for treatment of venous thrombosis, and both are safe for lactating mothers.
C) The treatment for superficial venous thrombosis involves resting the extremity, administering anti-inflammatory agents, and applying warm, moist compresses over the affected vein.
D) Methylergonovine is given only for postpartum hemorrhage and would cause vasoconstriction of an already inflamed vessel.
Page Ref: 1271
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.D. Analyze deep venous thrombosis (DVT) as it relates to perfusion. Differentiate care of patients with DVT across the lifespan.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with deep vein thrombosis.

4) The nurse is planning care for a client with deep venous thrombosis (DVT). Which problem would be a priority for this client?
A) Infection
B) Fluid volume
C) Peripheral perfusion
D) Sleep pattern
Answer: C
Explanation: A) Infection would be a priority if complications of infection were present; however, this is not the case.
B) Fluid volume is not related to the underlying cause.
C) A problem with peripheral tissue perfusion is the priority, because it is related to obstructed venous return, which is the underlying cause of the DVT.
D) Sleep pattern is not related to the underlying cause.
Page Ref: 1272
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Diagnosis
Learning Outcome: 16.D. Analyze deep venous thrombosis (DVT) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with DVT.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with deep vein thrombosis.

5) The nurse is providing discharge teaching to a client recovering from deep venous thrombosis (DVT). Which instructions are appropriate for the nurse to include in the teaching session?

Select all that apply.

A) Avoid crossing the legs
B) Avoid long car trips
C) Avoid prolonged standing or sitting
D) Take frequent walks
E) Take a daily aspirin dose of 650 mg

Answer: A, C, D

Explanation: A) The client should be instructed to avoid crossing the legs because it increases pressure on the veins of the lower extremities.

B) The client does not need to be instructed to avoid long car trips but rather to take frequent breaks during long car trips.

C) The client should be instructed to avoid prolonged standing or sitting, which contributes to venous stasis.

D) The client should be instructed to take frequent walks to promote venous return.

E) The client should not be instructed to take a daily aspirin, because it will increase anticoagulant activity and could interact with other medication prescribed for the treatment of the DVT.

Page Ref: 1273

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.2 Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation

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Learning Outcome: 16.D. Analyze deep venous thrombosis (DVT) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with DVT.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with deep vein thrombosis.

6) A client diagnosed with a deep vein thrombosis (DVT) is receiving intravenous heparin. Which is the priority outcome for this client?
A) The client will not disturb the intravenous infusion.
B) The client will comply with dietary restrictions.
C) The client will not experience bleeding.
D) The client will keep the right leg elevated on two pillows.
Answer: C
Explanation: A) Disturbing the intravenous line could relate to bleeding, but this does not directly correlate with heparin.
B) Dietary restrictions are important, but not as high a priority as an absence of bleeding.
C) An absence of bleeding is a priority outcome for any client receiving anticoagulant therapy.
D) Elevation of the affected extremity is important, but not as high a priority as an absence of bleeding.
Page Ref: 1272
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.D. Analyze deep venous thrombosis (DVT) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with DVT.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with deep vein thrombosis.

7) A client receiving heparin therapy for deep venous thrombosis (DVT) complains of severe chest pain and shortness of breath. Suspecting a pulmonary embolism, which is the priority action by the nurse?
A) Assess pulse, respirations, and blood pressure.
B) Apply oxygen and elevate the head of the bed.
C) Reassure the client and notify family members.
D) Increase the rate of heparin infusion.
Answer: B
Explanation: A) Assessing pulse, respiration, and blood pressure will be performed following the initiation of oxygen therapy and bed elevation.
B) Applying oxygen and elevating the head of the bed will promote ventilation and gas exchange in those alveoli that are well perfused, helping to maintain tissue oxygenation.
C) Although reassuring the client and notifying family members are important, they are not a higher priority than promoting oxygenation.
D) Increasing the rate of heparin infusion cannot be done by the nurse without an order from a healthcare provider.
Page Ref: 1273
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.D. Analyze deep venous thrombosis (DVT) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with DVT.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with deep vein thrombosis.

8) A client being treated for deep venous thrombosis (DVT) is experiencing pain. Which interventions should the nurse implement? **Select all that apply.**
A) Place an egg-crate mattress on the bed.
B) Maintain bedrest as ordered.
C) Apply warm, moist heat to the area four times a day.
D) Encourage position changes every 2 hours.
E) Measure calf and thigh diameter daily.
Answer: B, C, E
Explanation: A) Placing an egg-crate mattress on the bed would be appropriate for the client experiencing problems with peripheral tissue perfusion.
B) Interventions to address pain include maintaining bedrest as ordered.
C) Interventions to address pain include applying warm, moist heat to the area four times a day.
D) Encouraging position changes every 2 hours would be appropriate for the client experiencing problems with peripheral tissue perfusion.
E) Interventions to address pain include measuring calf and thigh diameter daily.
Page Ref: 1273
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.D. Analyze deep venous thrombosis (DVT) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with DVT.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with deep vein thrombosis.

9) Which term will the nurse use that describes the three pathological factors that are associated with the formation of a thrombus?
A) Rastelli syndrome
B) Holter triad
C) Vena cava syndrome
D) Virchow's triad
Answer: D
Explanation: A) The Rastelli procedure is used to repair some congenital heart defects.
B) A Holter monitor is used to record the electrical activity of the heart over 24 to 48 hours.
C) A vena cava filter is used to prevent thrombi from traveling up to the heart from the legs.
D) Three pathological factors, called Virchow's triad, are associated with the formation of a thrombus: circulatory stasis, vascular damage, and hypercoagulability.
Page Ref: 1265
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.D. Analyze deep venous thrombosis (DVT) as it relates to perfusion. Describe the pathophysiology of DVT.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with deep vein thrombosis.

10) Which characteristic of veins increases the risk for the development of a thrombus?
A) Low blood flow
B) High pressure
C) Retrograde blood flow
D) Presence of plaque
Answer: A
Explanation: A) Venous thrombi tend to occur at sites where the vein is normal but blood flow is low.
B) High pressure in the veins does not stimulate the formation of a thrombus.
C) Retrograde blood flow is associated with postthrombotic syndrome, which occurs after a deep vein thrombosis has already developed.
D) Arterial thrombi tend to occur at sites of arterial plaque rupture.
Page Ref: 1266
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.D. Analyze deep venous thrombosis (DVT) as it relates to perfusion. Describe the etiology of DVT.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with deep vein thrombosis.

11) Which diagnostic test is invasive and used to assess and diagnose venous thrombosis?
A) Venography
B) Duplex venous ultrasonography
C) Magnetic resonance imaging
D) Plethysmography
Answer: A
Explanation: A) Venography is the only invasive test.
B) Duplex venous ultrasonography is a noninvasive test using sound waves to provide vein visualization.
C) MRI uses strong magnetic fields to generate images of structures within the body.
D) Plethysmography is a noninvasive test that measures blood flow as it moves through the veins.
Page Ref: 1266
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.D. Analyze deep venous thrombosis (DVT) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with DVT.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with deep vein thrombosis.

12) Both a 40-year-old male and a 70-year-old male are placed on anticoagulant therapy after diagnosis of a deep vein thrombosis (DVT). When providing teaching to these clients about their medication, in which way should the nurse individualize care for each?
A) The younger client will need more frequent monitoring than the older client.
B) The older client will need more frequent monitoring than the younger client.
C) The older client will take a lower dose than the younger client.
D) The younger client will take a lower dose than the older client.
Answer: B
Explanation: A) The younger client will not need more frequent monitoring.
B) Anticoagulant therapy is commonly used to treat both older and younger adults with DVT. Most drugs are administered in a similar fashion and at comparable doses in older and younger clients, but monitoring may occur more frequently in older adults.
C) The dose is not contingent upon the client's age.
D) The dose is not contingent upon the client's age.
Page Ref: 1272
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2 Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.D. Analyze deep venous thrombosis (DVT) as it relates to perfusion. Differentiate care of patients with DVT across the lifespan.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with deep vein thrombosis.

Exemplar 16.E Disseminated Intravascular Coagulation

1) A client is admitted to the intensive care unit with disseminated intravascular coagulation (DIC). Which clinical manifestations does the nurse anticipate? Select all that apply.
A) Tachycardia
B) Increased blood glucose level
C) Decreased breath sounds
D) Confusion
E) Thick, tenacious bronchial secretions
Answer: A, C, D
Explanation: A) Clinical manifestations of DIC include tachycardia.
B) Increased blood glucose is not associated with this health problem.
C) Clinical manifestations of DIC include decreased breath sounds.
D) Clinical manifestations of DIC include confusion.
E) Thick bronchial secretions are not associated with this health problem.
Page Ref: 1277
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.E. Analyze disseminated intravascular coagulation (DIC) as it relates to perfusion. Identify the clinical manifestations of DIC.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with disseminated intravascular coagulation.

2) The nurse is caring for a client who has been admitted to labor and delivery. Which risk factors for disseminating intravascular coagulation (DIC) should the nurse identify for this client? **Select all that apply.**

A) Multiparity

B) Placental abruption

C) Preterm labor

D) Prior fetal death

E) Gestational diabetes

Answer: B, D

Explanation: A) Multiparity does not cause DIC.

B) The risk of developing DIC increases in pregnant women who have placental abruption.

C) Preterm labor does not cause DIC.

D) The risk of developing DIC increases in pregnant women who have had fetal death.

E) Gestational diabetes does not cause DIC.

Page Ref: 1278

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment

Learning Outcome: 16.D. Analyze disseminated intravascular coagulation (DIC) as it relates to perfusion. Differentiate care of patients with DIC across the lifespan.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with disseminated intravascular coagulation.

3) The nurse is caring for a client with disseminated intravascular coagulation (DIC). Which should the nurse identify as a priority intervention for this client?
A) Frequent ambulation
B) Maintenance of skin integrity
C) Preparation for radiograph procedures
D) Restricting fluids
Answer: B
Explanation: A) The client with DIC should be placed on bedrest.
B) Impairment of skin integrity can lead to bleeding in DIC.
C) DIC is not diagnosed with radiograph examination but by serum lab studies.
D) Fluids need to be monitored but will not be restricted.
Page Ref: 1279
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.E. Analyze disseminated intravascular coagulation (DIC) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with DIC.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with disseminated intravascular coagulation.

4) A client with disseminated intravascular coagulation (DIC) is anxious and has decreased oxygen saturation. Which is the priority problem for this client?
A) Acute pain
B) Inadequate gas exchange
C) Impaired peripheral tissue perfusion
D) Fear
Answer: B
Explanation: A) Decreased oxygen saturation and anxiety would not be addressed with the problem of acute pain.
B) The decrease in oxygen saturation is a result of impairment in the client's gas exchange.
C) Decreased oxygen saturation and anxiety would not be addressed with the problem of impaired peripheral tissue perfusion.
D) Fear could contribute to the client's impaired gas exchange but is not the primary problem to address.
Page Ref: 1279
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Diagnosis
Learning Outcome: 16.E.7. Analyze disseminated intravascular coagulation (DIC) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with DIC.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with disseminated intravascular coagulation.

5) The nurse has identified the problem of impaired peripheral tissue perfusion for a client with disseminated intravascular coagulation (DIC). Which intervention would be appropriate for the client?

A) Carefully repositioning the client every 2 hours
B) Administering oxygen
C) Monitoring oxygen saturation
D) Encouraging deep breathing and coughing

Answer: A

Explanation: A) The intervention appropriate for the client experiencing impaired peripheral tissue perfusion is to carefully reposition the client every 2 hours because position changes facilitate circulation and tissue perfusion.

B) Administering oxygen would be appropriate if the client were experiencing impaired gas exchange.

C) Monitoring oxygen saturation would be appropriate if the client were experiencing impaired gas exchange.

D) Deep breathing and coughing would be appropriate if the client were experiencing impaired gas exchange.

Page Ref: 1279

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning

Learning Outcome: 16.E. Analyze disseminated intravascular coagulation (DIC) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with DIC.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with disseminated intravascular coagulation.

6) The nurse is evaluating care provided to a client with disseminated intravascular coagulation (DIC). Which finding indicates care has been successful for this client?
A) Heart rate 110 beats per minute
B) Oxygen saturation level 86%
C) Urine output 20 mL per hour
D) No evidence of bleeding
Answer: D
Explanation: A) Heart rate of 110 beats per minute would indicate the need for further treatment.
B) Oxygen saturation of 86% would indicate the need for further treatment.
C) Urine output of 20 mL per hour would indicate the need for further treatment.
D) Care provided to a client with DIC is successful when there is no further bleeding.
Page Ref: 1280
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Evaluation
Learning Outcome: 16.E. Analyze disseminated intravascular coagulation (DIC) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with DIC.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with disseminated intravascular coagulation.

7) A client with disseminated intravascular coagulation (DIC) is currently bleeding through the gastrointestinal tract. Which medication does the nurse anticipate administering to this client as a first line treatment?
A) Aspirin
B) Warfarin
C) Fresh frozen plasma and platelets
D) Heparin
Answer: C
Explanation: A) Aspirin and is not indicated in the treatment of DIC.
B) Warfarin is not indicated in the treatment of DIC.
C) When bleeding is the major manifestation of DIC, fresh frozen plasma and platelet concentrates are given to restore clotting factors and platelets.
D) Heparin may be administered if bleeding is not controlled by plasma and platelets and if the client has manifestations of thrombotic problems.
Page Ref: 1277
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.E. Analyze disseminated intravascular coagulation (DIC) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with DIC.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with disseminated intravascular coagulation.

8) A client with disseminated intravascular coagulation (DIC) is experiencing joint pain. Which nursing intervention is appropriate for this client?
A) Splints
B) Cool compresses
C) Heat
D) Ice
Answer: B
Explanation: A) Splints may hinder joint mobility and are not indicated for the care of this client.
B) Joint pain associated with DIC can be reduced by applying cool compresses to the affected joints to reduce the transmission of pain impulses.
C) Heat will encourage bleeding and should not be applied to this client.
D) Ice should not be applied but rather cool compresses.
Page Ref: 1279
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.E. Analyze disseminated intravascular coagulation (DIC) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with DIC.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with disseminated intravascular coagulation.

10) The nurse is assessing a client during labor and delivery. Which condition should the nurse recognize as a risk factor for disseminated intravascular coagulation (DIC)?
A) Gestational diabetes
B) Polyhydramnios
C) Placental abruption
D) Placenta previa
Answer: C
Explanation: A) Gestational diabetes is not a risk factor for DIC.
B) Polyhydramnios is not a risk factor for DIC.
C) Acute DIC can occur in pregnant clients, most often with pregnancies complicated by preeclampsia, placental abruption, fetal demise, amniotic fluid embolism, and septic abortion.
D) Placenta previa is not a risk factor for DIC.
Page Ref: 1278
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.E. Analyze disseminated intravascular coagulation (DIC) as it relates to perfusion. Differentiate care of patients with DIC across the lifespan.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with disseminated intravascular coagulation.

11) A client with disseminated intravascular coagulation (DIC) has the problem of impaired peripheral tissue perfusion. Which actions are appropriate for this problem? **Select all that apply.**

A) Monitor the client's level of consciousness and mental status.
B) Elevate the client's knees on the bed or with a pillow.
C) Minimize the use of tape on the client's skin.
D) Assess extremity pulses, warmth, and capillary refill.
E) Carefully reposition the client at least every 2 hours.

Answer: A, C, D, E

Explanation: A) The nurse should monitor the client's level of consciousness and mental status due to the risk of cerebral emboli.

B) The nurse should not elevate the client's knees on the bed or with a pillow because this may impair arterial and venous flow to the lower legs and feet, increasing vascular stasis and the risk for thrombosis.

C) Preventing skin trauma reduces the risk for bleeding.

D) The nurse will assess extremity pulses, warmth, and capillary refill, which facilitates the early treatment of impaired perfusion.

E) Position changes facilitate circulation and tissue perfusion and provide an opportunity to assess for purpura, pallor, and bleeding.

Page Ref: 1279

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation

Learning Outcome: 16.E. Analyze disseminated intravascular coagulation (DIC) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with DIC.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with disseminated intravascular coagulation.

12) A client with disseminated intravascular coagulation (DIC) has the problem of inadequate gas exchange. Which action is appropriate when providing care based on this problem?
A) Place the client in the Fowler position
B) Monitor the client's oxygen saturation intermittently
C) Encourage frequent ambulation
D) Use continuous endotracheal suctioning instead of coughing and deep breathing
Answer: A
Explanation: A) Micro clots in the pulmonary vasculature are likely to interfere with gas exchange in the client with DIC. The nurse should place the client in Fowler or high-Fowler position to improve gas exchange.
B) Oxygen saturation levels are a noninvasive means of assessing gas exchange and should be monitored continuously.
C) The client must remain on bedrest to reduce oxygen demands and cardiac workload.
D) Cautious nasotracheal suctioning is indicated only if cough is ineffective or an endotracheal tube is in place. Deep breathing increases respiratory depth and improves alveolar ventilation and oxygenation.
Page Ref: 1279
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.E. Analyze disseminated intravascular coagulation (DIC) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with DIC.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with disseminated intravascular coagulation.

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13) Which pathological change related to disseminated intravascular coagulation (DIC) occurs late in the course of the disease?
A) Hemorrhage
B) Formation of small clots
C) Damage to the endothelium
D) Brain ischemia
Answer: A
Explanation: A) When clotting factors are depleted and fibrin degradation products are released, hemorrhage occurs.
B) The presence of thrombin causes small clots to form in the microvasculature.
C) Damage to the endothelium is one of the triggers that stimulates the clotting cascade.
D) If thrombi and emboli impair tissue perfusion, ischemia of organs such as the brain can occur.
Page Ref: 1276
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.E. Analyze disseminated intravascular coagulation (DIC) as it relates to perfusion. Describe the pathophysiology of DIC.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with disseminated intravascular coagulation.

Exemplar 16.F Heart Failure

1) The nurse is caring for a client with congestive heart failure (CHF) who frequently wakes during the night frightened and short of breath. Which condition is the client experiencing?
A) Cardiomyopathy
B) Paroxysmal nocturnal dyspnea
C) High-output failure
D) Multisystem heart failure
Answer: B
Explanation: A) The client is not experiencing cardiomyopathy.
B) Paroxysmal nocturnal dyspnea occurs when edema fluid that has accumulated during the day is reabsorbed into the circulation at night. This causes fluid overload and pulmonary congestion. The client awakens at night short of breath and frightened.
C) The client is not experiencing high-output failure.
D) The client is not experiencing multisystem heart failure.
Page Ref: 1285
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.F. Analyze heart failure (HF) as it relates to perfusion. Identify the clinical manifestations of HF.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with heart failure.

2) The nurse is planning care for several clients. Which client should the nurse identify as being at greatest risk of developing heart failure?
A) A 69-year-old black male with hypertension
B) A 50-year-old black female who smokes
C) A 75-year-old white male who is overweight
D) A 52-year-old white female with asthma
Answer: A
Explanation: A) Age above 65, black race, and hypertension lead to an increased risk for developing heart failure. The 69-year-old black male with hypertension has three risk factors.
B) A female who is under age 65 is not at the greatest risk for heart failure despite smoking.
C) Overweight is not a risk factor for heart failure.
D) Asthma is not a risk factor for heart failure.
Page Ref: 1284
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.F. Analyze heart failure (HF) as it relates to perfusion. Compare the risk factors and prevention of HF.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with heart failure.

3) The nurse is caring for a child with congestive heart failure (CHF). Which clinical manifestations does the nurse anticipate when assessing this child? **Select all that apply.**
A) Excessive sweating
B) Hypertension
C) Bradycardia
D) Difficulty breathing
E) Increased appetite
Answer: A, D
Explanation: A) Symptoms in children include excessive sweating.
B) Symptoms in children include low blood pressure (not hypertension).
C) Bradycardia is not a typical finding in children with heart failure.
D) Symptoms in children include difficulty breathing.
E) Symptoms in children include poor feeding or growth (not increased appetite).
Page Ref: 1294
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.F. Analyze heart failure (HF) as it relates to perfusion. Differentiate care of patients with HF across the lifespan.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with heart failure.

4) During an assessment, a client with left-sided congestive heart failure (CHF) and severe shortness of breath tells the nurse about not having enough money to purchase medications. Which problem is of the greatest initial importance when planning care?
A) Fluid volume excess
B) Inability to manage health
C) Nonadherence to therapeutic plan
D) Inability to tolerate activity
Answer: A
Explanation: A) The client is experiencing acute shortness of breath because of the excess fluid. Fluid volume excess is the priority at this time.
B) Inability to manage health related to the inability to purchase medications should be addressed after the client's physiological problems are resolved.
C) Nonadherence to therapeutic plan related to the inability to purchase medications should be addressed after the client's physiological problems are resolved.
D) Inability to tolerate activity will improve once the fluid volume excess is addressed.
Page Ref: 1295
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Diagnosis
Learning Outcome: 16.F. Analyze heart failure (HF) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with HF.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with heart failure.

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5) The nurse is assessing a client being treated for congestive heart failure (CHF). Which physical findings would indicate that the client's condition is deteriorating? **Select all that apply.**
A) Urine output 160 ml over 8 hours
B) Pulse oximetry reading of 96%
C) Temperature of 98.6°F (37°C)
D) Wheezing of breath sounds in all lobes
E) Moderate amount of clear, thin mucus
Answer: A, D
Explanation: A) A urine output of less than 30 ml/hour should be reported to the healthcare provider and is an indication of a worsening of CHF.
B) A pulse oximetry reading of 96% is a normal finding.
C) A temperature reading of 98.6°F is a normal finding.
D) Wheezing heard when assessing breath sounds is indicative of abnormal breath sounds, which are characteristic in CHF.
E) Moderate clear mucus is a normal finding.
Page Ref: 1296
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.F. Analyze heart failure (HF) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with HF.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with heart failure.

6) A client is prescribed enalapril (Vasotec) for treatment of heart failure. Which adverse effect should the nurse assess for following the initial administration of this drug?
A) Jaundice
B) Ototoxicity
C) Low blood pressure
D) Blurred vision
Answer: C
Explanation: A) Jaundice is an adverse effect of diuretics.
B) Ototoxicity is an adverse effect of diuretics.
C) Severe hypotension can occur after the initial administration of enalapril (Vasotec).
D) Blurred vision is a sign of digitalis toxicity.
Page Ref: 1290
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Evaluation
Learning Outcome: 16.F. Analyze heart failure (HF) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with HF.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with heart failure.

7) The nurse is positioning a client with left-sided heart failure in bed. Which sleeping position is most appropriate for this client?
A) Reclining with 3 pillows under head
B) Lying on the left side with 1 pillow under head
C) Lying supine with 1 pillow under head
D) Lying in the Sims position with 2 pillows under head
Answer: A
Explanation: A) The client with left-sided cardiac failure could develop orthopnea. Being in an upright position with 3 pillows under the head will ease the work of breathing.
B) Lying on the left side, will not help alleviate or prevent the development of orthopnea.
C) Lying supine will not help alleviate or prevent the development of orthopnea.
D) Lying in the Sims position, even with 1-2 pillows, will not help alleviate or prevent the development of orthopnea.
Page Ref: 1285
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2 Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.F. Analyze heart failure (HF) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with HF.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with heart failure.

8) The nurse is assessing a client. Which condition should the nurse recognize as a noncardiac risk factor for heart failure?
A) Myocardial Infarction
B) Hypertension
C) Hyperthyroidism
D) Congenital Heart Defects
Answer: C
Explanation: A) Heart failure may be caused by acute cardiac events such as myocardial function.
B) Heart failure may be caused by acute cardiac events such as conditions causing increased cardiac workload (hypertension).
C) Heart failure may be caused by noncardiac conditions, such as hyperthyroidism.
D) Heart failure may be caused by acute cardiac events such as conditions causing increased cardiac workload (congenital defects).
Page Ref: 1284
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.F. Analyze heart failure (HF) as it relates to perfusion. Describe the etiology of HF.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with heart failure.

9) Which statement is true about the physiology of neuroendocrine compensatory mechanism?
A) Increased venous return increases ventricular filling and myocardial stretch, increasing the force of contraction.
B) Decreased cardiac output stimulates the sympathetic nervous system and catecholamine release.
C) Increased renal perfusion stimulates the renin-angiotensin system.
D) Antidiuretic hormone is released from the adrenal gland.
Answer: B
Explanation: A) In the Frank-Starling mechanism, increased venous return increases ventricular filling and myocardial stretch, increasing the force of contraction.
B) In the neuroendocrine response, the cardiac output is decreased. This stimulates the sympathetic nervous system, causing catecholamine release.
C) Decreased cardiac output combined with decreased renal perfusion stimulates the renin-angiotensin system.
D) Antidiuretic hormone is released from the posterior pituitary.
Page Ref: 1282
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.F. Analyze heart failure (HF) as it relates to perfusion. Describe the pathophysiology of HF.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with heart failure.

10) A client with heart failure is admitted to the hospital for the placement of an implantable defibrillator. The client appears comfortable at rest but displays dyspnea with activities of daily living (ADLs). In which way should the nurse classify this client's heart failure?
A) Class I
B) Class II
C) Class III
D) Class IV
Answer: C
Explanation: A) In class I, the client has no limitations in physical activity.
B) In class II the client has some physical limitations due to fatigue.
C) This client has class III heart failure, or moderate heart failure. In this stage, the client is comfortable at rest but displays dyspnea with less than normal physical activity. Also, in this stage, surgical intervention includes implantation of a defibrillator.
D) In class IV, any physical activity causes discomfort.
Page Ref: 1287
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.F. Analyze heart failure (HF) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with HF.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with heart failure.

11) The nurse is planning care for a client with systolic heart failure. Which pathophysiology should the nurse recall about this condition?
A) Occurs when the ventricle fails to contract adequately to eject a sufficient volume of blood into the arterial system
B) Results when the heart cannot completely relax in diastole, disrupting normal filling
C) Decreases passive diastolic filling, increasing the importance of atrial contraction to preload
D) Results from decreased ventricular compliance caused by hypertrophic and cellular changes and impaired relaxation of the heart muscle
Answer: A
Explanation: A) Systolic heart failure occurs when the ventricle fails to contract adequately to eject a sufficient volume of blood into the arterial system.
B) Inability of the heart to relax in diastole describes diastolic heart failure.
C) Decreased passive diastolic filling occurs in diastolic heart failure.
D) Decreased ventricular compliance occurs in diastolic heart failure.
Page Ref: 1283
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.F. Analyze heart failure (HF) as it relates to perfusion. Describe the pathophysiology of HF.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with heart failure.

12) The nurse is counseling a female client who wants to become pregnant. The client was diagnosed with heart failure 3 years ago and has class II heart failure. What information should the nurse include when teaching related to pregnancy and heart failure?
A) Women with class II heart failure should not attempt to become pregnant.
B) Women with class II heart failure should receive additional monitoring during pregnancy.
C) Women with class II heart failure should take ACE inhibitors during the pregnancy.
D) Women with class II heart failure should stop taking diuretics during the pregnancy.
Answer: B
Explanation: A) Women with stage II heart failure may be able to carry and deliver a baby.
B) Women with stage II heart failure should be counseled about risk prior to becoming pregnant and should be carefully monitored during pregnancy and the postpartum period.
C) ACE inhibitors are contraindicated during pregnancy due to potential adverse effects on the fetus.
D) Diuretics are commonly prescribed for pregnant women with heart failure, especially if pulmonary edema is present.
Page Ref: 1294
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.F. Analyze heart failure (HF) as it relates to perfusion. Differentiate care of patients with heart failure (HF) across the lifespan.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with heart failure.

Exemplar 16.G Hypertension

1) A client reports morning headaches that extend into the neck and go away as the day wears on. Based on this initial data, which assessment finding does the nurse anticipate?
A) Elevated blood pressure
B) Tachycardia
C) Otitis media
D) Swollen lymph nodes
Answer: A
Explanation: A) A headache, generally in the back of the head and neck, that is present on awakening and subsides during the day is an early sign of hypertension. The nurse would expect that the client's blood pressure would be elevated.
B) This type of headache is not directly associated with tachycardia.
C) This type of headache is not directly associated with otitis media.
D) This type of headache is not directly associated with swollen lymph nodes.
Page Ref: 1303
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.G. Analyze hypertension (HTN) as it relates to perfusion. Identify the clinical manifestations of HTN.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with hypertension.

2) The nurse teaches a client about lifestyle modifications to help manage hypertension. Which client statement indicates teaching has been effective?

A) "I won't be able to run in marathons anymore."
B) "I know I need to give up my cigarettes and alcohol."
C) "I need to get started on my medications right away."
D) "My father had hypertension, did nothing, and lived to be 90 years old."

Answer: B

Explanation: A) Increasing physical activity is an important lifestyle modification for controlling hypertension.

B) Limiting intake of alcohol and discontinuing tobacco products are important nonpharmacologic methods for controlling hypertension.

C) Implementing lifestyle modifications may eliminate the need for pharmacotherapy, so the client may not have to take medication right away.

D) The fact that the client's father had hypertension and lived to be 90 years old does not mean that the client will have the same experience; the client is in denial.

Page Ref: 1302

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Evaluation

Learning Outcome: 16.G. Analyze hypertension (HTN) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with HTN.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with hypertension.

3) The nurse is caring for a client who has not been adhering to treatment with antihypertension medication. Which approach to addressing this issue should the nurse use?
A) Indifference
B) Nonjudgmental
C) Demanding
D) Confrontational
Answer: B
Explanation: A) Indifference will likely elicit a negative response from the client, and the client will be less likely to change his behavior.
B) The nurse who listens to the client openly and nonjudgmentally will both validate the client's self-esteem and communicate the idea of partnership in the treatment plan for the client.
C) A demanding attitude will likely elicit a negative response from the client, and the client will be less likely to change his behavior.
D) A confrontational attitude will likely elicit a negative response from the client, and the client will be less likely to change his behavior.
Page Ref: 1309
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.G. Analyze hypertension (HTN) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with HTN.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with hypertension.

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4) An older adult client receiving medication for hypertension had a recent fall at home. Which intervention should the nurse include in this client's plan of care?
A) Monitor serum sodium levels
B) Assess postural blood pressures
C) Monitor serum creatinine levels
D) Monitor blood pressure every 2 hours
Answer: B
Explanation: A) Sodium levels assess renal function.
B) Baroreceptors are less efficient with aging. Therefore, orthostatic hypotension is more likely to occur. Also, clients treated for hypertension could have an increase in sensitivity to the medications. Postural blood pressure assessment allows the nurse to prevent orthostatic hypotension and falls.
C) Creatinine levels assess renal function.
D) Every 2 hours is too frequent for assessments of a noncritical client.
Page Ref: 1309
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.G. Analyze hypertension (HTN) as it relates to perfusion. Differentiate care of patients with hypertension (HTN) across the lifespan.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with hypertension.

5) The nurse instructs a client about the medication nifedipine (Procardia) for hypertension. Which client statement indicates that additional teaching is needed?
A) "This medication will cause my ankles to swell, which is normal."
B) "I need to drink 6 to 8 glasses of water each day."
C) "I will call my doctor if I gain weight or become short of breath."
D) "I need to eat foods high in fiber when taking this medication."
Answer: A
Explanation: A) Swelling in the feet or ankles when taking this medication should be reported to the healthcare provider.
B) This medication can cause constipation, so drinking 6 to 8 glasses of water each day is appropriate.
C) The client should notify the healthcare provider of weight gain or shortness of breath.
D) This medication can cause constipation, so increasing fiber in the diet is appropriate.
Page Ref: 1306
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Evaluation
Learning Outcome: 16.G. Analyze hypertension (HTN) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with HTN.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with hypertension.

6) The nurse is caring for a client with hypertension. Which diagnostic tests should the nurse anticipate being ordered to rule out secondary causes? **Select all that apply.**
A) Cerebral angiogram
B) Intravenous pyelogram
C) Renal ultrasonography
D) Cardiac catheterization
E) Myelogram
Answer: B, C
Explanation: A) Cerebral angiogram is not a diagnostic test to determine the cause for secondary hypertension.
B) When secondary hypertension is suspected, diagnostic tests include an intravenous pyelogram to determine if the renal system is the cause of the hypertension.
C) When secondary hypertension is suspected, diagnostic tests include renal ultrasonography to determine if the renal system is the cause of the hypertension.
D) Cardiac catheterization is not a diagnostic test to determine the cause for secondary hypertension.
E) Myelogram is not a diagnostic test to determine the cause for secondary hypertension.
Page Ref: 1304
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning

Learning Outcome: 16.G. Analyze hypertension (HTN) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with HTN.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with hypertension.

7) A client has a blood pressure of 142/92 mmHg. Which classification is appropriate for the nurse to use when documenting this data?
A) Normal
B) Stage 2
C) Elevated
D) Stage 1
Answer: B
Explanation: A) Normal blood pressure is less than 120/80.
B) Stage 2 hypertension is systolic at least 140 or diastolic at least 90.
C) Elevated blood pressure is systolic from 120-129 and diastolic less than 80.
D) Stage 1 hypertension is systolic from 130-139 or diastolic from 80-89.
Page Ref: 1299
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.G. Analyze hypertension (HTN) as it relates to perfusion. Describe the pathophysiology of HTN.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with hypertension.

8) Which statement best describes the effects of the renal system on blood pressure?
A) "The release of the catecholamines epinephrine and norepinephrine cause an increase in blood pressure."
B) "The release of renin causes an increase in blood pressure."
C) "The release of atrial natriuretic peptide (ANP) and brain natriuretic peptide (BNP) cause an increase in blood pressure."
D) "The synthesis and release of adrenomedullin causes an increase in blood pressure."
Answer: B
Explanation: A) A drop in renal perfusion stimulates renin release. Renin converts angiotensinogen to angiotensin I, which is then converted to angiotensin II in the lungs. Angiotensin II is a vasoconstrictor and also promotes sodium and water retention, raising blood pressure. Catecholamines help regulate blood pressure, but they are not released from the kidneys.
B) A drop in renal perfusion stimulates renin release. Renin converts angiotensinogen to angiotensin I, which is then converted to angiotensin II in the lungs. Angiotensin II is a vasoconstrictor and also promotes sodium and water retention, raising blood pressure.
C) ANP and BNP help regulate blood pressure, but they are not released from the kidneys.
D) Adrenomedullin helps regulate blood pressure, but it is not released from the kidneys.
Page Ref: 1300
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.G. Analyze hypertension (HTN) as it relates to perfusion. Describe the pathophysiology of HTN.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with hypertension.

9) A client with primary hypertension is prescribed terazosin (Hytrin) to treat this condition. Which statement explains the mechanism of action of this drug?
A) Prevents conversion of angiotensin I to angiotensin II
B) Prevents beta-receptor stimulation in the heart
C) Inhibits the flow of calcium ions across the cell membrane of vascular tissue and cardiac cells
D) Blocks alpha-receptors in the vascular smooth muscle
Answer: D
Explanation: A) ACE inhibitor medications prevent conversion of angiotensin I to angiotensin II.
B) Beta-adrenergic blockers prevent beta-receptor stimulation in the heart.
C) Calcium channel blockers inhibit the flow of calcium ions across the cell membrane of vascular tissue and cardiac cells.
D) Terazosin (Hytrin), an alpha-adrenergic blocker, acts by blocking alpha-receptors in the vascular smooth muscle.
Page Ref: 1304
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.G. Analyze hypertension (HTN) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with HTN.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with hypertension.

10) Which risk factor for hypertension is modifiable?
A) Age
B) Ethnicity
C) Family history
D) Tobacco use
Answer: D
Explanation: A) Age is a nonmodifiable risk factor for hypertension.
B) Ethnicity is a nonmodifiable risk factor for hypertension.
C) Family history is a nonmodifiable risk factor for hypertension.
D) Hypertension has many modifiable risk factors, including tobacco use, high sodium intake, obesity, excess alcohol consumption, and low activity level.
Page Ref: 1302
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.G. Analyze hypertension (HTN) as it relates to perfusion. Compare the risk factors and prevention of HTN.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with hypertension.

11) Which physiological changes associated with aging increase the risk of hypertension in older adults?

A) Increase in systolic blood pressure
B) Increase in diastolic blood pressure
C) Increase in the pulse pressure
D) Decrease in the diastolic blood pressure
Answer: A
Explanation: A) An age-related increase in the systolic blood pressure is the primary factor leading to the high incidence of hypertension in older adults.
B) The diastolic blood pressure tends to rise until approximately age 50 and then declines.
C) The pulse pressure, which is the difference between the systolic and diastolic blood pressures, does not determine hypertension status.
D) A decrease in diastolic blood pressure does not cause HTN.
Page Ref: 1308-1309
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.G. Analyze hypertension (HTN) as it relates to perfusion. Describe the etiology of HTN.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with hypertension.

12) Which strategy helps prevent hypertension?
A) Increase salt intake
B) Reduce physical activity
C) Decrease stress
D) Take hot baths
Answer: C
Explanation: A) Reducing salt intake helps prevent hypertension.
B) Increasing physical activity helps prevent hypertension.
C) Decreasing stress helps prevent hypertension.
D) Baths that are too hot can increase blood pressure.
Page Ref: 1302
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.G. Analyze hypertension (HTN) as it relates to perfusion. Compare the risk factors and prevention of HTN.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with hypertension.

13) The nurse is caring for a 13-year-old female with a BMI of 30.4. When taking the child's vital signs, the nurse documents a blood pressure of 121/83. In which way would this blood pressure be categorized for this client?

A) Normal blood pressure
B) Primary hypertension
C) Secondary hypertension
D) Hypotension

Answer: B

Explanation: A) For a 13-year-old female, the systolic blood pressure should be between 96-103 mmHg and the diastolic blood pressure should be between 58-61 mmHg. This is not a normal blood pressure for the client.

B) Primary hypertension in a client of this age is often associated with obesity. A BMI of 30.4 is categorized as obese.

C) Secondary HTN is often associated with kidney, heart, or endocrine abnormalities. There is no evidence of these conditions in the client.

D) Hypertension is defined as having blood pressure above the 95th percentile.

Page Ref: 1308

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment

Learning Outcome: 16.G. Analyze hypertension (HTN) as it relates to perfusion. Differentiate care of patients with HTN across the lifespan.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with hypertension.

Exemplar 16.H Hypertensive Disorders in Pregnancy

1) The nurse is assessing a client who is in the third trimester of pregnancy. Which finding would require immediate intervention by the nurse?
A) Blood pressure of 142/92 mmHg
B) Pulse of 92 beats per minute
C) Respiratory rate of 24 per minute
D) Weight gain of 16 oz per week
Answer: A
Explanation: A) A pregnant client's blood pressure should not be greater than 140/90 mmHg, and if it is elevated, it could be a sign of gestational hypertension or preeclampsia.
B) The pregnant client's heart rate will increase slightly as a result of an increased circulatory volume and a decrease in intrathoracic space.
C) The pregnant client's respiratory rate will increase slightly as a result of an increased circulatory volume and a decrease in intrathoracic space.
D) Weight gain should average a pound per week in the second and third trimesters.
Page Ref: 1312
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.H. Analyze hypertensive disorders of pregnancy as they relate to perfusion. Describe the pathophysiology of hypertensive disorders of pregnancy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with a hypertensive disorder in pregnancy.

2) The nurse is assessing a client who is 20 weeks pregnant. Which health issue should the nurse recognize as increasing this client's risk for the development of preeclampsia?
A) Treatment for vitamin D deficiency
B) Surgery for ruptured appendix 1-year prior
C) Fibrocystic breast disease
D) Diabetes
Answer: D
Explanation: A) Treatment for vitamin D deficiency does not increase the risk for preeclampsia.
B) Previous surgeries will not increase the risk for preeclampsia.
C) Fibrocystic breast disease does not increase the risk for preeclampsia.
D) One risk factor for the development of preeclampsia is diabetes.
Page Ref: 1313
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.H. Analyze hypertensive disorders of pregnancy as they relate to perfusion. Compare the risk factors and prevention of hypertensive disorders of pregnancy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with a hypertensive disorder in pregnancy.

3) The nurse identifies assessment findings for a client with preeclampsia. Blood pressure is 158/100 mmHg; urinary output 50 mL/hour; crackles in the lungs on auscultation; urine protein 1+; 1+ edema hands, feet, ankles. On the next hourly assessment, which new assessment finding would indicate worsening of the condition?
A) Blood pressure 159/100 mmHg
B) Urinary output 40 mL/hour
C) Urine protein 2+
D) Lungs clear to auscultation
Answer: C
Explanation: A) The blood pressure increase is not significant.
B) Urinary output is still greater than 30 mL/hour, so this is not concerning yet.
C) The assessment finding most abnormal is the increase in urine protein. This indicates worsening of the condition.
D) Lungs clear to auscultation is an improvement in the client's condition.
Page Ref: 1313
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment

Learning Outcome: 16.H. Analyze hypertensive disorders of pregnancy as they relate to perfusion. Identify the clinical manifestations of hypertensive disorders of pregnancy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with a hypertensive disorder in pregnancy.

4) During a routine prenatal visit, a client who is 24 weeks pregnant has a blood pressure of 143/91. The client's blood pressure at her previous visit was 121/82. A urine dipstick test reveals a trace amount of protein. The nurse identifies which problem as appropriate for the client at this time?
A) Fluid volume excess
B) Potential for injury
C) Difficulty with breastfeeding
D) Anxiety
Answer: A
Explanation: A) The rise in blood pressure and protein in the urine could indicate that preeclampsia is developing. Because preeclampsia is often accompanied by fluid retention, the client would be at risk for fluid volume excess.
B) There is no evidence that the client is at risk for an injury.
C) The client has not delivered yet and would not have difficulty with breastfeeding.
D) Anxiety can be addressed after the client's physiologic problems are addressed.
Page Ref: 1316
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Diagnosis
Learning Outcome: 16.H. Analyze hypertensive disorders of pregnancy as they relate to perfusion. Apply the nursing process in providing culturally competent care to an individual with a hypertensive disorder of pregnancy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with a hypertensive disorder in pregnancy.

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5) The community nurse is caring for a client who is 32 weeks pregnant and diagnosed with preeclampsia. Which statement indicates that the client requires additional teaching?
A) "It is normal for my urine to become darker and smaller in amount each day."
B) "I should call the doctor if I develop a headache or blurred vision."
C) "Pain in the top of my abdomen is a sign my condition is worsening."
D) "Lying on my left side as much as possible is good for the baby."
Answer: A
Explanation: A) Oliguria is a complication of preeclampsia caused by renal involvement and is a sign that the condition is worsening. It is not an expected outcome and should be reported to the physician.
B) Headache and blurred vision or other visual disturbances are an indication of worsening preeclampsia and should be reported to the physician.
C) Epigastric pain is an indication of liver enlargement, a symptom of worsening preeclampsia, and should be reported to the physician.
D) Left lateral position maximizes uterine and renal blood flow, and therefore is the optimal position for a client with preeclampsia.
Page Ref: 1314
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment

Learning Outcome: 16.H. Analyze hypertensive disorders of pregnancy as they relate to perfusion. Apply the nursing process in providing culturally competent care to an individual with a hypertensive disorder of pregnancy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with a hypertensive disorder in pregnancy.

6) The nurse is providing postpartum care for a client who gave birth by cesarean section several hours ago. The client had preeclampsia during the last 3 weeks of pregnancy. Which interventions are appropriate for this client within the first 48 hours after birth? **Select all that apply.**
A) Assessment of deep tendon reflexes
B) Assessment of intake and output
C) Oxygen 2 liters nasal cannula as prescribed
D) Seizure precautions
E) Vital sign assessment
Answer: A, B, D, E
Explanation: A) Nursing management during the postpartal period includes deep tendon reflexes.
B) Nursing management during the postpartal period includes intake and output assessment.
C) Oxygen is not usually indicated after delivery.
D) Even though the client with preeclampsia usually improves rapidly after giving birth, seizures can still occur during the first 48 hours postpartum.
E) Nursing management during the postpartal period includes vital sign assessment.
Page Ref: 1315
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.H. Analyze hypertensive disorders of pregnancy as they relate to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a hypertensive disorder of pregnancy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with a hypertensive disorder in pregnancy.

7) A client with preeclampsia begins to demonstrate manifestations of seizure activity. Which intervention by the nurse is most likely to protect the client and fetus from injury?

A) Elevate the client's legs
B) Place the client on the left side and protect the airway
C) Place the client in the supine position
D) Elevate the head of the bed

Answer: B

Explanation: A) The client's legs should not be elevated.

B) The client should be placed on the side to aid in circulation to the placenta. The airway needs to be maintained to ensure oxygenation throughout the seizure.

C) The client should not be placed in the supine position.

D) The head of the bed should not be elevated.

Page Ref: 1317

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.2 Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation

Learning Outcome: 16.H. Analyze hypertensive disorders of pregnancy as they relate to perfusion. Apply the nursing process in providing culturally competent care to an individual with a hypertensive disorder of pregnancy.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with a hypertensive disorder in pregnancy.

8) The nurse is teaching a group of pregnant clients regarding seizures associated with eclampsia. Which statement associated with eclampsia is accurate?
A) "The tonic phase of a grand mal seizure is evidenced by alternate contraction and relaxation of the muscles."
B) "The clonic phase of a grand mal seizure is evidenced by muscular contraction and rigidity."
C) "Seizures are rare in eclampsia, but they occur sometimes."
D) "Seizures do not occur in preeclampsia."
Answer: D
Explanation: A) The tonic phase of a grand mal seizure is evidenced by muscular contraction and rigidity.
B) The clonic phase of a grand mal seizure is evidenced by alternate contraction and relaxation of the muscles.
C) Seizures do not occur in preeclampsia; eclampsia is diagnosed once a client has a seizure, so seizures are not rare in eclampsia.
D) Seizures do not occur in preeclampsia; eclampsia is diagnosed once a client has a seizure, so seizures are not rare in eclampsia.
Page Ref: 1317
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.H. Analyze hypertensive disorders of pregnancy as they relate to perfusion. Describe the pathophysiology of hypertensive disorders of pregnancy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with a hypertensive disorder in pregnancy.

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9) The nurse is caring for a client with preeclampsia. Which laboratory value does the nurse anticipate for this client?
A) Increased platelet count
B) Decreased liver enzymes
C) Decreased blood urea nitrogen (BUN)
D) Increased serum creatinine
Answer: D
Explanation: A) Preeclampsia can cause a decrease in platelet count.
B) Preeclampsia can cause an increase in liver enzymes.
C) Preeclampsia decreases renal perfusion, causing an increase in blood urea nitrogen (BUN).
D) Preeclampsia decreases renal perfusion, causing an increase in serum creatinine.
Page Ref: 1314
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.H. Analyze hypertensive disorders of pregnancy as they relate to perfusion. Identify the clinical manifestations of hypertensive disorders of pregnancy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with a hypertensive disorder in pregnancy.

10) A pregnant client is diagnosed with HELLP syndrome. Based on this diagnosis, which laboratory findings are consistent with diagnosis of HELLP?
A) Decreased liver enzymes
B) Hemolysis
C) Elevated lipid panel
D) Increased platelet count
Answer: B
Explanation: A) HELLP syndrome causes elevated liver enzymes.
B) HELLP syndrome causes hemolysis.
C) An elevated lipid panel is not a characteristic of HELLP syndrome.
D) HELLP syndrome causes a low platelet count.
Page Ref: 1313
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.H. Analyze hypertensive disorders of pregnancy as they relate to perfusion. Identify the clinical manifestations of hypertensive disorders of pregnancy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with a hypertensive disorder in pregnancy.

11) Which action should the nurse carry out for the laboring client who has been diagnosed with preeclampsia?
A) Place the client in the room closest to the nurse's station, even if it is a shared room.
B) Place the client in left lateral position when the client feels the urge to push.
C) Monitor client's fetus intermittently while client is in first stage of labor.
D) Encourage the client to be alone in the room without family in order to maintain a quiet environment.
Answer: B
Explanation: A) If possible, the nurse should place the client in a private room to promote a nonstimulating environment.
B) A laboring client with preeclampsia is at risk for the development of eclampsia with subsequent seizures. The nurse should place the client in left lateral position because this position improves circulation to the placenta and fetus; the client should remain in this position when pushing if possible.
C) The nurse will monitor the client's fetus continuously during labor.
D) The client should always have support and not be alone during labor.
Page Ref: 1317
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.H. Analyze hypertensive disorders of pregnancy as they relate to perfusion. Apply the nursing process in providing culturally competent care to an individual with a hypertensive disorder of pregnancy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with a hypertensive disorder in pregnancy.

12) Which situation is believed to be the cause of preeclampsia?
A) Placental dysfunction
B) Liver disease
C) Anxiety
D) Low sodium intake
Answer: A
Explanation: A) The exact cause of preeclampsia is unknown. However, it has been identified as a disorder of placental dysfunction leading to a syndrome of endothelial dysfunction with associated vasospasm.
B) Eclampsia is not caused by liver disease.
C) Eclampsia is not caused by anxiety.
D) Eclampsia is not caused by low sodium intake.
Page Ref: 1312
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.H. Analyze hypertensive disorders of pregnancy as they relate to perfusion. Describe the etiology of hypertensive disorders of pregnancy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with a hypertensive disorder in pregnancy.

13) The nurse is caring for a pregnant client who is hypertensive. Which additional clinical manifestation leads the nurse to believe that the client is experiencing early preeclampsia?
A) Persistent headache
B) Excessive protein in the urine
C) Right-sided abdominal pain
D) Severe epigastric pain
Answer: B
Explanation: A) Later symptoms include persistent headache.
B) Early signs of preeclampsia include protein in the urine.
C) Later symptoms include right-sided abdominal pain.
D) Severe epigastric pain is a symptom of HELLP syndrome.
Page Ref: 1313
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.H. Analyze hypertensive disorders of pregnancy as they relate to perfusion. Identify the clinical manifestations of hypertensive disorders of pregnancy.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with a hypertensive disorder in pregnancy.

Exemplar 16.I Life-Threatening Dysrhythmias

1) During a blood pressure screening, an older adult client tells the nurse about chest fluttering while doing yard work. The client reports no other symptoms, and the frequency is intermittent. Which action is correct by the nurse?
A) Suggest the client stop exercising
B) Reassure these are normal changes associated with aging
C) Ensure the client is evaluated by their medical provider
D) Check laboratory values for hypothyroidism
Answer: C
Explanation: A) Exercise intolerance would include shortness of breath, which the client does not report.
B) These symptoms are not normal cardiac changes.
C) New-onset dysrhythmias may signal the onset of a serious underlying illness that requires further medical evaluation.
D) Chest fluttering can be a sign of hyperthyroidism, not hypothyroidism.
Page Ref: 1327
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.I. Analyze life-threatening dysrhythmias as they relate to perfusion. Differentiate care of patients with life-threatening dysrhythmias across the lifespan.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with life threatening dysrhythmias.

2) The nurse is assessing an adult client with a cardiac dysrhythmia. Which finding would the nurse identify as possibly contributing to this client's dysrhythmia?

A) Drinks caffeinated coffee in the morning and for lunch

B) Does not smoke or ingest any alcohol

C) Plays golf three times a week and gardens daily

D) Takes antihypertensive medication as prescribed

Answer: A

Explanation: A) Caffeine increases the risk of ectopic beats and rapid heart rates.

B) The client is a non-smoker and does not ingest alcohol, both of which would contribute to cardiac dysrhythmias.

C) Engaging in routine physical activity will not cause dysrhythmias or conduction defects.

D) Antihypertensive medications are not associated with cardiac dysrhythmias.

Page Ref: 1324

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment

Learning Outcome: 16.I. Analyze life-threatening dysrhythmias as they relate to perfusion. Compare the risk factors and prevention of life-threatening dysrhythmias.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with life threatening dysrhythmias.

3) An adult client is experiencing paroxysmal supraventricular tachycardia. Which nursing interventions are appropriate based on the data provided? **Select all that apply.**
A) Initiate oxygen therapy
B) Prepare for cardioversion
C) Begin anticoagulation therapy as prescribed
D) Administer intravenous adenosine as prescribed
E) Administer a beta blocker as prescribed
Answer: A, B, D, E
Explanation: A) Management of paroxysmal supraventricular tachycardia includes oxygen therapy.
B) Management of paroxysmal supraventricular tachycardia includes synchronized cardioversion.
C) Anticoagulant therapy is not a part of the management for this dysrhythmia.
D) Management of paroxysmal supraventricular tachycardia includes adenosine.
E) Management of paroxysmal supraventricular tachycardia includes beta blockers.
Page Ref: 1322
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.I. Analyze life-threatening dysrhythmias as they relate to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a life-threatening dysrhythmia.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with life threatening dysrhythmias.

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4) A client with a cardiac dysrhythmia reports being easily fatigued and has difficulty performing normal daily activities. Which problem should the nurse select to address this client's issue?
A) Excessive amount of body fluid
B) Inability to tolerate activity
C) Fear
D) Inability to perform self-care
Answer: B
Explanation: A) There is no evidence that the client is experiencing excess fluid volume.
B) The client is experiencing fatigue and frustration with the inability to perform normal daily activities. The problem to address this client's issue would be inability to tolerate activity.
C) There is no evidence that the client is experiencing fear.
D) There is no evidence that the client has the inability to perform self-care.
Page Ref: 1336
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Diagnosis
Learning Outcome: 16.I. Analyze life-threatening dysrhythmias as they relate to perfusion. Apply the nursing process in providing culturally competent care to an individual with a life-threatening dysrhythmia.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with life threatening dysrhythmias.

5) The nurse is planning care for a client with a cardiac dysrhythmia. Which action would be the most appropriate for this client?

A) Restrict fluids

B) Encourage bedrest

C) Monitor serum electrolyte levels

D) Instruct on a low-fat diet

Answer: C

Explanation: A) There is no evidence to suggest the client needs to have fluids restricted.

B) More information is needed before determining whether the client needs to be on bedrest.

C) The nurse should monitor serum electrolyte levels because electrolyte imbalances affect cardiac depolarization and repolarization and may cause dysrhythmias.

D) There is no evidence to suggest the client needs instruction on a low-fat diet.

Page Ref: 1327

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation

Learning Outcome: 16.I. Analyze life-threatening dysrhythmias as they relate to perfusion. Apply the nursing process in providing culturally competent care to an individual with a life-threatening dysrhythmia.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with life threatening dysrhythmias.

6) A client is receiving procainamide hydrochloride for treatment of a dysrhythmia. Which is an appropriate client outcome related to adhering to the provided medication instruction?

A) The client will monitor the pulse and not take the medication if the pulse is less than 60.

B) The client will take the medication as directed, even when feeling well.

C) The client will take the medication on an empty stomach.

D) The client will take the medication with food.

Answer: B

Explanation: A) The beta-adrenergic blocking drugs cause bradycardia, not group 1A cardiac antiarrhythmic drugs like procainamide hydrochloride.

B) It is very important for clients to understand that medication must be taken as directed, even if the client is feeling well.

C) Procainamide hydrochloride can be taken on an empty stomach.

D) Procainamide hydrochloride can be taken with food.

Page Ref: 1329, 1336

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning

Learning Outcome: 16.I. Analyze life-threatening dysrhythmias as they relate to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a life-threatening dysrhythmia.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with life threatening dysrhythmias.

7) A client is scheduled for temporary pacemaker insertion. Which instruction will this client need prior to discharge?
A) Dizziness is to be expected.
B) There are no special precautions.
C) Wear a tight-fitting shirt to help hold the pacemaker in place.
D) Use battery-powered equipment.
Answer: D
Explanation: A) Dizziness is not to be expected and should be reported to the healthcare provider.
B) There are special precautions that the client needs to take.
C) The client should wear loose-fitting clothing.
D) When available, battery-powered equipment should be used instead of electrical equipment.
Page Ref: 1331
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.I. Analyze life-threatening dysrhythmias as they relate to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a life-threatening dysrhythmia.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with life threatening dysrhythmias.

8) A client with sepsis has a temperature of 40°C. Which dysrhythmia is most likely to occur in this client?
A) Bradydysrhythmia
B) Tachydysrhythmia
C) Wolff-Parkinson-White dysrhythmia
D) Long QT dysrhythmia
Answer: B
Explanation: A) Fever does not cause bradydysrhythmias.
B) Stressors such as fever, sepsis, and hyperthyroidism may precipitate paroxysmal supraventricular tachycardia, which is a tachydysrhythmia.
C) Wolff-Parkinson-White is caused by genetic cardiac problems.
D) Long QT is caused by genetic cardiac problems.
Page Ref: 1321, 1325
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.I. Analyze life-threatening dysrhythmias as they relate to perfusion. Identify the clinical manifestations of life-threatening dysrhythmias.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with life threatening dysrhythmias.

9) The nurse notes that a client is experiencing a ventricular tachycardia dysrhythmia. Which rhythm is a type of ventricular tachycardia?
A) Sinus tachycardia
B) Atrial flutter
C) Junctional escape
D) Torsades de Pointes
Answer: D
Explanation: A) Sinus tachycardia is a supraventricular rhythm, not a ventricular rhythm.
B) Atrial flutter is not a ventricular rhythm.
C) Junctional escape rhythm is not a ventricular rhythm.
D) Torsades de Pointes is a type of ventricular tachycardia.
Page Ref: 1326
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.I. Analyze life-threatening dysrhythmias as they relate to perfusion. Identify the clinical manifestations of life-threatening dysrhythmias.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with life threatening dysrhythmias.

10) The nurse is participating in the resuscitation of a client experiencing sudden cardiac death. After five cycles of CPR, the nurse evaluates the client's cardiac rhythm as asystole. Which action should the nurse take next?
A) Administer epinephrine
B) Immediately defibrillate the client
C) Assess the cardiac monitor electrodes
D) Assess the client's pulse
Answer: D
Explanation: A) Epinephrine is not given next.
B) Defibrillation is not indicated.
C) Cardiac monitor electrodes should not be on the client.
D) According to the American Heart Association (AHA) CPR guidelines, after five rounds of CPR, the nurse should assess the client's pulse. All other choices are incorrect actions by the nurse.
Page Ref: 1334
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.I. Analyze life-threatening dysrhythmias as they relate to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a life-threatening dysrhythmia.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with life threatening dysrhythmias.

11) Which property of cardiac cells is mechanical in nature?
A) Automaticity
B) Excitability
C) Conductivity
D) Contractility
Answer: D

Explanation: A) Automaticity is the capability of pacemaker cells to initiate an electrical impulse or action potential.

B) Excitability is the capability of heart muscle cells to respond to electrical stimulation from the pacemaker cells.

C) Conductivity is the capability of myocardial cells to transfer the electrical impulses from cell to cell in a rapid fashion.

D) Contractility is the capability of myocardial fibers to shorten with electrical stimulation. A single muscle fiber stimulation triggers the rest of the muscle mass to contract as a single unit in an all-or-nothing system.

Page Ref: 1320
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.I. Analyze life-threatening dysrhythmias as they relate to perfusion. Describe the pathophysiology of life-threatening dysrhythmias.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with life threatening dysrhythmias.

12) Which dysrhythmia is most commonly associated with sudden cardiac death (SCD)?
A) Atrial flutter
B) Ventricular fibrillation
C) Paroxysmal supraventricular tachycardia
D) Junctional escape rhythm
Answer: B
Explanation: A) Atrial flutter is not associated with SCD.
B) Ventricular fibrillation most commonly leads to sudden cardiac death.
C) Paroxysmal supraventricular tachycardia is not associated with SCD.
D) A junctional escape rhythm is not associated with SCD.
Page Ref: 1323, 1326
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.I. Analyze life-threatening dysrhythmias as they relate to perfusion. Describe the etiology of life-threatening dysrhythmias.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with life threatening dysrhythmias.

13) The nurse is caring for a 6-year-old child when the child goes into cardiac arrest. When performing compressions for CPR, which action should the nurse take?
A) Place thumbs side by side and perform compressions below the nipple line
B) Use two fingers in the upright position to perform compressions
C) Use two fingers plus the heel of the other hand to perform compressions
D) Use both hands on the lower half of the breastbone to perform compressions
Answer: C
Explanation: A) When performing CPR on neonates, thumbs should be placed side by side, or overlapping in very small neonates, and compressions should be performed below the nipple line.
B) For infants, two fingers placed in the upright position should be used for compressions.
C) For children, the provider should use two fingers plus the heel of the other hand to perform compressions.
D) For adults, use both hands on the lower half of the breastbone to perform compressions.
Page Ref: 1335
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2 Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.I. Analyze life-threatening dysrhythmias as they relate to perfusion. Differentiate care of patients with life-threatening dysrhythmias across the lifespan.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with life threatening dysrhythmias.

Exemplar 16.J Peripheral Vascular Disease

1) A client admitted with chronic venous insufficiency has an infected wound of the left lower extremity. Which clinical manifestations does the nurse anticipate during the client's assessment? **Select all that apply.**
A) Pulses absent in the extremity with the wound
B) Wound that is pink with skin warm
C) Ulceration that is pale in color
D) Skin surrounding ulcer that is cool to the touch
E) Surrounding skin brown in color
Answer: B, E
Explanation: A) An ulcer with absent pulses is an arterial ulcer.
B) Manifestations of a venous status ulcer are a pink wound with warm skin.
C) An ulcer that is pale in color is an arterial ulcer.
D) An ulcer with cool skin temperature is an arterial ulcer.
E) Manifestations of a venous status ulcer include areas of hyperpigmentation.
Page Ref: 1341
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.J. Analyze peripheral vascular disease (PVD) as it relates to perfusion. Identify the clinical manifestations of PVD.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with peripheral vascular disease.

2) A client diagnosed with peripheral vascular disease (PVD) is obese, has a 30-year history of cigarette smoking, and works as a contractor. When discussing risk factors for PVD, which statement by the nurse is appropriate?
A) "Nicotine causes vasospasms, which reduce blood flow to the legs."
B) "Obesity is a factor in cardiovascular disease but not peripheral vascular disease."
C) "Nicotine primarily affects coronary arteries and the lungs."
D) "Your current occupation is a major risk factor."
Answer: A
Explanation: A) The vasoconstrictive properties of nicotine will worsen the client's PVD by further decreasing peripheral blood flow. One of the most important parts of treatment is the cessation of cigarette smoking.
B) Obesity is a risk factor for both cardiovascular disease and PVD.
C) The vasoconstrictive properties of nicotine will worsen the client's PVD by further decreasing peripheral blood flow.
D) The client's occupation is not a risk factor related to PVD.
Page Ref: 1340
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.J. Analyze peripheral vascular disease (PVD) as it relates to perfusion. Compare the risk factors and prevention of PVD.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with peripheral vascular disease.

3) The nurse is planning care for an older adult client with chronic venous insufficiency. Which will the nurse include in the client's teaching plan?
A) Keep the legs dependent as much as possible and elevate only when asleep.
B) Wear elastic hose as prescribed.
C) Standing will prevent the progression of the disease.
D) Cross legs only at the knees.
Answer: B
Explanation: A) The legs should be elevated during rest and when asleep.
B) The nurse should instruct the client to wear elastic hose as prescribed.
C) The nurse should instruct the client to avoid sitting or standing for long periods of time.
D) Crossing the legs should be avoided.
Page Ref: 1342
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.J. Analyze peripheral vascular disease (PVD) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with PVD.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with peripheral vascular disease.

4) The nurse is planning care for a client with peripheral vascular disease (PVD) who is at risk for compromised skin integrity. Which intervention is appropriate for the nurse to include in the plan of care?
A) Restrict fluids
B) Keep the skin clean and dry, and moisturize areas of dryness
C) Encourage bedrest with legs elevated on pillows
D) Consult a dietitian for low-protein diet
Answer: B
Explanation: A) A fluid restriction would dry tissues and not promote good skin turgor.
B) The client with PVD who is at risk for compromised skin integrity should have meticulous skin care to keep the skin clean, dry, and well-moisturized to prevent skin breakdown.
C) Bedrest with legs elevated on pillows could increase the client's pain and would not help with preventing skin breakdown.
D) A low-protein diet is not beneficial for wound healing and may not be indicated for this client.
Page Ref: 1343
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.J. Analyze peripheral vascular disease (PVD) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with PVD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with peripheral vascular disease.

5) The nurse is evaluating teaching provided to a client with peripheral vascular disease (PVD). Which client observation indicates teaching has been effective?
A) Sitting in a chair with a pillow behind knees
B) Washing the lower extremities with mild soap, drying the legs, and applying a light moisturizer
C) Sitting in a chair with left leg crossed over the right
D) Smoking a pipe instead of cigarettes
Answer: B
Explanation: A) Sitting in a chair with a pillow behind the knees would indicate further instruction was needed.
B) The client who is observed washing the legs with mild soap, drying the legs, and applying a moisturizer is putting into practice the instruction regarding PVD.
C) Sitting in a chair with legs crossed would indicate further instruction was needed.
D) The client smoking a pipe instead of cigarettes needs additional instruction regarding the hazards of tobacco.
Page Ref: 1343
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Evaluation
Learning Outcome: 16.J. Analyze peripheral vascular disease (PVD) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with PVD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with peripheral vascular disease.

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6) A client with peripheral vascular disease (PVD) asks what types of exercise would improve the client's condition and overall health. Which type of exercise will the nurse include in the response to the client?
A) Passive ROM
B) Weightlifting
C) Yoga
D) Team sports
Answer: C
Explanation: A) Active ROM exercises should be encouraged rather than passive ROM exercises.
B) Weightlifting may increase blood pressure and cause harm to fragile blood vessels.
C) Yoga is considered a complementary therapy used to reduce stress and improve circulation.
D) Clients with PVD should have gradual increases in duration and intensity of exercise, so team sports would not be appropriate.
Page Ref: 1183
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.J. Analyze peripheral vascular disease (PVD) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with PVD.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with peripheral vascular disease.

7) A client with peripheral vascular disease (PVD) is experiencing pain. Which nursing intervention addresses the client's pain?
A) Elevate legs in bed
B) Keep the extremities warm
C) Encourage to ambulate several times each day
D) Apply cool compresses to the extremities
Answer: B
Explanation: A) Elevating the legs in bed is more appropriate for promoting tissue perfusion and will not immediately address the client's pain.
B) The nurse should help keep the client's extremities warm, as heat promotes vasodilation and reduces pain.
C) Encouraging the client to ambulate is more appropriate for promoting tissue perfusion and will not immediately address the client's pain.
D) Cool compresses will constrict vessels and cause more pain.
Page Ref: 1343
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.J. Analyze peripheral vascular disease (PVD) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with PVD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with peripheral vascular disease.

8) A client with peripheral vascular disease (PVD) has symptoms of intermittent claudication. Which information should the nurse include when teaching the client about intermittent claudication?
A) It causes pain that occurs during periods of inactivity.
B) It causes pain that increases when the legs are elevated and decreases when the legs are dependent.
C) It causes cramping or aching pain in the lower extremities and the buttocks that occurs with a predictable level of activity.
D) It is often described as a burning sensation in the lower legs.
Answer: C
Explanation: A) Intermittent claudication does not occur during rest.
B) Intermittent claudication does not occur with elevating legs.
C) Intermittent claudication is a cramping or aching pain in the calves of the legs, the thighs, and the buttocks that occurs with a predictable level of activity. The pain is often accompanied by weakness and is relieved by rest.
D) Intermittent claudication does not cause burning pain.
Page Ref: 1340
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.J. Analyze peripheral vascular disease (PVD) as it relates to perfusion. Identify the clinical manifestations of PVD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with peripheral vascular disease.

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9) A client is admitted to the hospital for a surgical intervention due to peripheral vascular disease (PVD). The nurse should be prepared to answer questions about which procedure?
A) Stent placement
B) Endarterectomy
C) Percutaneous transluminal angioplasty
D) Atherectomy
Answer: B
Explanation: A) Stent placement is considered non-surgical.
B) Surgical intervention for PVD includes endarterectomy and bypass grafts.
C) Percutaneous transluminal angioplasty is considered non-surgical.
D) Atherectomy is considered non-surgical.
Page Ref: 1342
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.J. Analyze peripheral vascular disease (PVD) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with PVD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with peripheral vascular disease.

10) Which statement explains the development of brown pigmentation of the lower extremities in clients with venous stasis?
A) The necrosis of subcutaneous fat due to tissue hypoxia
B) Breakdown of red blood cells in the congested tissues
C) Reduced inflammatory and immune response from congested circulation
D) Skin atrophy caused by lack of circulation
Answer: B
Explanation: A) Brown discoloration of skin is not caused by necrosis of subcutaneous fat.
B) Breakdown of red blood cells in the congested tissues causes brown skin pigmentation.
C) Brown discoloration is not caused by reduced inflammatory and immune response from congested circulation.
D) Brown discoloration is not caused by skin atrophy.
Page Ref: 1340-1341
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.J. Analyze peripheral vascular disease (PVD) as it relates to perfusion. Describe the pathophysiology of PVD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with peripheral vascular disease.

11) The home care nurse is explaining the application of an Unna boot to a client with a stasis ulcer. Which statement about this dressing is accurate?
A) "A nurse will change this dressing every 2 days."
B) "It is important that you maintain strict bedrest."
C) "The dressing will be applied to the entire length of your leg."
D) "The dressing I am applying is semi-rigid."
Answer: D
Explanation: A) The dressing will be changed every 1-2 weeks, depending on ulcer drainage.
B) The dressing allows a client to be ambulatory and does not make the client maintain strict bedrest.
C) The dressing covers the foot and lower leg but not the entire leg.
D) The Unna boot therapy is a semi-rigid dressing used to treat stasis ulcers.
Page Ref: 1341
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.J. Analyze peripheral vascular disease (PVD) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with PVD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with peripheral vascular disease.

12) Which form of peripheral vascular disease is characterized by thickening, loss of elasticity, and calcification of arterial walls?
A) Arteriosclerosis
B) Atherosclerosis
C) Chronic venous insufficiency
D) Deep venous thrombosis
Answer: A
Explanation: A) Arteriosclerosis is characterized by thickening, loss of elasticity, and calcification of arterial walls.
B) Atherosclerosis is a form of arteriosclerosis in which deposits of fat and fibrin obstruct and harden the arteries.
C) Chronic venous insufficiency is a disorder of inadequate venous return over a prolonged period.
D) Deep venous thrombosis is the presence of a blood clot in a deep vein.
Page Ref: 1340
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.J. Analyze peripheral vascular disease (PVD) as it relates to perfusion. Describe the pathophysiology of PVD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with peripheral vascular disease.

13) Which client has the highest risk of developing peripheral vascular disease (PVD)?
A) 83-year-old black male
B) 78-year-old black female
C) 64-year-old Hispanic male
D) 75-year-old White female
Answer: A
Explanation: A) PVD primarily affects older adults, with greater prevalence seen in adults over age 80 who are black and male.
B) Men are more often affected then women.
C) People of Hispanic origin seem to have similar risk when compared to non-Hispanic whites.
D) Whites are not at higher risk than other races.
Page Ref: 1340
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.J. Analyze peripheral vascular disease (PVD) as it relates to perfusion. Describe the etiology of PVD.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with peripheral vascular disease.

Exemplar 16.K Pulmonary Embolism

1) The nurse is caring for a client who is recovering from a hysterectomy. Which clinical manifestation supports that the client is experiencing a pulmonary embolism (PE)?
A) Nausea
B) Decreased urine output
C) Dyspnea and chest pain
D) Activity intolerance
Answer: C
Explanation: A) Nausea is not a clinical manifestation of a PE.
B) Decreased urine output is not a clinical manifestation of a PE.
C) The most common symptoms of PE are dyspnea and pleuritic chest pain.
D) Activity intolerance is not a clinical manifestation of a PE.
Page Ref: 1345
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.K. Analyze pulmonary embolism (PE) as it relates to perfusion. Identify the clinical manifestations of PE.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with pulmonary embolism.

2) The nurse is concerned that a client admitted for a total hip replacement is at risk for thrombus formation. Which assessment finding caused the nurse to draw this conclusion?
A) Body mass index (BMI) 35.8
B) Former cigarette smoker
C) Blood pressure 132/88 mmHg
D) Age 45 years
Answer: A
Explanation: A) Risk factors for the development of thrombus formation that could lead to a pulmonary embolism include obesity, orthopedic surgery, myocardial infarction, heart failure, and advancing age. The BMI of 35.8 falls into the category of obese, which would increase the client's risk of developing a thrombus and possible pulmonary embolism.
B) The client's status as a former smoker does not have as significant an impact on the development of a thrombus as the client's weight.
C) The client's blood pressure would not have as significant an impact on the development of a thrombus as the client's weight.
D) The client's age would not have as significant an impact on the development of a thrombus as the client's weight.
Page Ref: 1345
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment

Learning Outcome: 16.K. Analyze pulmonary embolism (PE) as it relates to perfusion. Compare the risk factors and prevention of PE.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with pulmonary embolism.

3) The nurse is providing discharge instructions to an older adult client who is going home after having a total knee replacement. Which should the nurse include in the discharge teaching to decrease the client's risk for developing a thrombosis or pulmonary embolism (PE)? **Select all that apply.**

A) Place pillows under the knees when in bed.
B) Use compression stockings.
C) Limit ambulation.
D) Limit fluids.
E) Continue with leg exercises.

Answer: B, E

Explanation: A) The client should avoid placing pillows under the knees.
B) The nurse should instruct the client to use compression stockings to reduce the risk of deep vein thrombosis formation.
C) The client should be encouraged to ambulate.
D) The client should be well hydrated unless another physiological condition exists that would necessitate a fluid restriction.
E) The nurse should instruct the client to continue with leg exercises to reduce the risk of deep vein thrombosis formation.

Page Ref: 1345
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.K. Analyze pulmonary embolism (PE) as it relates to perfusion. Compare the risk factors and prevention of PE.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with pulmonary embolism.

4) A client diagnosed with a pulmonary embolism has a reduction in arterial oxygen saturation level and dyspnea. Which is the priority problem for this client?
A) Decreased cardiac output
B) Anxiety
C) Compromised gas exchange
D) Inadequate protection
Answer: C
Explanation: A) The client may have decreased cardiac output; however, this is not the priority.
B) The client may be experiencing anxiety; however, this is not the priority at this time.
C) A reduction in arterial oxygen saturation level and dyspnea indicate the client is experiencing compromised gas exchange. This would be the priority for the client at this time.
D) There is not enough information to determine whether the client is at risk for inadequate protection.
Page Ref: 1348
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Diagnosis
Learning Outcome: 16.K. Analyze pulmonary embolism (PE) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with PE.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with pulmonary embolism.

5) The nurse is planning care for a client with a pulmonary embolism. Which nursing action would assist with the client's decrease in cardiac output?
A) Provide oxygen
B) Keep protamine sulfate at the bedside
C) Monitor pulmonary arterial pressures
D) Assess for bleeding
Answer: C
Explanation: A) Oxygen would be appropriate for the client with impaired gas exchange.
B) Keeping protamine sulfate at the bedside would be appropriate for the client who is taking heparin.
C) The client with a pulmonary embolism and decreased cardiac output is at risk for developing right heart failure. The nurse should monitor pulmonary arterial pressures.
D) Assessing for bleeding would be appropriate for the client who is taking heparin.
Page Ref: 1349
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.K. Analyze pulmonary embolism (PE) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with PE.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with pulmonary embolism.

6) The nurse is providing teaching about long-term anticoagulant therapy to a client recovering from a pulmonary embolism. Which client statement indicates that instruction has been effective?

A) "I will expect bloody sputum when I brush my teeth."
B) "I need to use a soft toothbrush and an electric razor to avoid injuries."
C) "I need to eat a well-balanced diet with green salads."
D) "I can expect to be bruised, since this is normal."

Answer: B

Explanation: A) Bloody sputum means the client is in need of additional instruction on anticoagulant therapy.
B) Instruction on anticoagulant therapy should include the need to avoid injury, use a soft toothbrush, and use an electric razor.
C) The client should avoid green salads because of the vitamin K content.
D) The statements about bruising being normal means the client is in need of additional instruction on anticoagulant therapy.

Page Ref: 1349
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Evaluation
Learning Outcome: 16.K. Analyze pulmonary embolism (PE) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with PE.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with pulmonary embolism.

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7) A client scheduled for surgery is being instructed in leg exercises and the pneumatic compression device. The nurse includes these instructions to decrease which postoperative complication?
A) Infection
B) Delayed wound healing
C) Contractures
D) Deep vein thrombosis
Answer: D
Explanation: A) Exercises and pneumatic compression devices do not prevent infection.
B) Exercises and pneumatic compression devices do not encourage wound healing.
C) Exercises and pneumatic compression devices do not prevent contractures.
D) The best care for a pulmonary embolism (PE) is prevention. Since surgical clients have an increased risk of developing a PE postoperatively, instructions should include ways to encourage movement, such as leg exercises, and the need for pneumatic compression devices to maintain lower extremity circulation and prevent the development of a deep vein thrombosis.
Page Ref: 1345
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.K. Analyze pulmonary embolism (PE) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with PE.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with pulmonary embolism.

8) The nurse is preparing to discharge a client recovering from a pulmonary embolism (PE). Which topics should the nurse include in the teaching session? **Select all that apply.**

A) Limit the use of over-the-counter medications
B) Diet to include green leafy vegetables
C) Symptoms of recurrence
D) Anticoagulant administration schedule
E) Resume normal activity level

Answer: C, D

Explanation: A) The client being discharged after treatment for a PE needs to be instructed in avoiding all over-the-counter medications.

B) The client being discharged after treatment for a PE needs to be instructed in avoiding green leafy vegetables because of vitamin K.

C) The nurse should instruct the client in symptoms recurrence of a PE.

D) The nurse should instruct the client in the schedule for anticoagulation administration.

E) The client being discharged after treatment for a PE needs to be instructed on adhering to the physician's prescribed activity level.

Page Ref: 1350

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.2 Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation

Learning Outcome: 16.K. Analyze pulmonary embolism (PE) as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with PE.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with pulmonary embolism.

9) The nurse is providing care to several clients on a medical-surgical unit. Which client is at highest risk for a nonthrombotic pulmonary embolism (PE)?
A) The client who is receiving intravenous pain medication
B) The client who is postoperative from a femur fracture repair
C) The client with a primary abdominal tumor
D) The client who uses intravenous illicit drugs
Answer: B
Explanation: A) IV pain medication does not increase the risk for a nonthrombotic pulmonary emboli.
B) Fat emboli are the most common nonthrombotic pulmonary emboli. A fat embolism usually occurs after fracture of long bone (typically the femur) releases bone marrow fat into the circulation.
C) A primary abdominal tumor does not increase the risk for a nonthrombotic pulmonary emboli.
D) Using IV illicit drugs does not increase the risk for a nonthrombotic pulmonary emboli.
Page Ref: 1345
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.K. Analyze pulmonary embolism (PE) as it relates to perfusion. Compare the risk factors and prevention of PE.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with pulmonary embolism.

10) The nurse is caring for a client who develops dyspnea and chest pain. Which diagnostic finding is consistent with a pulmonary embolism (PE)?

A) Lack of infiltrates on chest x-ray

B) Metabolic alkalosis on arterial blood gas

C) Elevated CO_2 level found on end-tidal carbon dioxide monitor

D) Tachycardia and nonspecific T-wave changes on EKG

Answer: D

Explanation: A) Pulmonary infiltration is common on a chest x-ray.

B) The client with a PE will likely have respiratory alkalosis from rapid breathing, not metabolic alkalosis.

C) The end-tidal CO_2 ($EtCO_2$) monitor will be decreased, not increased, due to rapid breathing.

D) With PE, tachycardia and nonspecific T-wave changes occur on EKG.

Page Ref: 1347

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment

Learning Outcome: 16.K. Analyze pulmonary embolism (PE) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with PE.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with pulmonary embolism.

11) The nurse is planning care for a newly admitted client diagnosed with pulmonary embolism (PE). The nurse anticipates the client will need anticoagulant therapy. Which statement is true regarding this therapy for the treatment of this condition?
A) It is considered second-line treatment.
B) Major hemorrhage is common.
C) Heparin and warfarin are usually initiated at the same time.
D) Heparin alters the synthesis of vitamin K-dependent clotting factors, preventing further clots.
Answer: C
Explanation: A) Anticoagulant therapy is the standard first-line treatment of PE.
B) While major hemorrhage is uncommon, bleeding may occur.
C) Heparin and warfarin are usually initiated at the same time for the treatment of PE.
D) Warfarin, not heparin, alters the synthesis of vitamin K-dependent clotting factors.
Page Ref: 1347
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.K. Analyze pulmonary embolism (PE) as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with PE.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with pulmonary embolism.

12) Which part of the respiratory structure increases after an embolus has become trapped in the pulmonary microvasculature?
A) Perfusion
B) Ventilation
C) Dead space
D) Alveolar surfactant
Answer: C
Explanation: A) Perfusion is decreased after a pulmonary embolism.
B) Ventilation is decreased after a pulmonary embolism.
C) Dead space, or areas of the lung that are ventilated but not perfused, increases.
D) Alveolar surfactant decreases, increasing the risk for atelectasis (collapsed lung).
Page Ref: 1345
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | | Nursing Process: Assessment
Learning Outcome: 16.K. Analyze pulmonary embolism (PE) as it relates to perfusion. Describe the pathophysiology of PE.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with pulmonary embolism.

13) The nurse is caring for a child with a fractured femur who complains of sudden chest pain and difficulty breathing. Which test would the nurse question if it was ordered by the physician?
A) D-dimer test
B) V/Q scans
C) Computerized tomography pulmonary angiography
D) Magnetic resonance pulmonary angiography
Answer: A
Explanation: A) Although V/Q scans, computerized tomography pulmonary angiography, and magnetic resonance pulmonary angiography are useful in diagnosing children with PE, the D-dimer test is not.
B) V/Q scans are useful in diagnosing children with PE.
C) Computerized tomography pulmonary angiography is useful in diagnosing children with PE.
D) Magnetic resonance pulmonary angiography is useful in diagnosing children with PE.
Page Ref: 1348
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.K. Analyze pulmonary embolism (PE) as it relates to perfusion. Differentiate care of patients with PE across the lifespan.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with pulmonary embolism.

14) The nurse is caring for a pregnant woman with a suspected pulmonary embolism without DVT. With regard to diagnostic tests to confirm the diagnosis which tests should the nurse anticipate being ordered for the client? **Select all that apply.**

A) V/Q scan

B) Computerized tomography pulmonary angiography

C) Chest x-ray

D) Non-stress test

E) Doppler ultrasound

Answer: A, B, C

Explanation: A) For pregnant women who have a suspected pulmonary embolism without DVT, a V/Q scan should be performed.

B) For pregnant women who have a suspected pulmonary embolism without DVT, computerized tomography pulmonary angiography should be done.

C) For pregnant women who have a suspected pulmonary embolism without DVT, a chest x-ray should be performed.

D) A non-stress test is not used to diagnose a pulmonary embolism.

E) A Doppler ultrasound may provide information of fetal wellbeing but is not used to diagnose a PE.

Page Ref: 1348

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning

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Learning Outcome: 16.K. Analyze pulmonary embolism (PE) as it relates to perfusion. Differentiate care of patients with PE across the lifespan.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with pulmonary embolism.

Exemplar 16.L Shock

1) Which assessment findings support the nurse's concern that a client is experiencing hypovolemic shock? **Select all that apply.**
A) Slight increase in pulse
B) Dry, warm skin
C) Increased urine output
D) Normal respirations
E) Slight decrease in blood pressure
Answer: A, D, E
Explanation: A) Manifestations of early hypovolemic shock include a slight increase in pulse.
B) Manifestations of early hypovolemic shock include cool, moist skin.
C) Manifestations of early hypovolemic shock include a slight decrease in urine output.
D) Manifestations of early hypovolemic shock include normal respirations.
E) Manifestations of early hypovolemic shock include slightly decreased blood pressure.
Page Ref: 1357
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.L. Analyze shock as it relates to perfusion. Identify the clinical manifestations of shock.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with shock.

2) A school-age client with a history of multiple allergies is prescribed epinephrine (EpiPen™) for prevention of anaphylactic shock. The client's mother says to the nurse, "I thought shock was about heart failure." Which response by the nurse is the most appropriate?
A) "Allergic response is the most fatal type of shock; other types involve loss of blood, heart failure, and liver failure."
B) "Heart failure is the most serious kind of shock; others include infection, kidney failure, and loss of blood."
C) "There are many kinds of shock that also include infection, nervous system damage, and loss of blood."
D) "There are many kinds of shock: heart failure, nervous system damage, loss of blood, and respiratory failure."
Answer: C
Explanation: A) Liver failure is not a type of shock.
B) Kidney failure is not a type of shock.
C) Obvious bleeding suggests hypovolemic shock; trauma to the brain or spinal cord suggests neurogenic shock; inadequate cardiac output suggests cardiogenic shock; a recent infection may indicate septic shock; and a history of allergies with a sudden onset of symptoms may suggest anaphylactic shock.
D) Respiratory failure is not a type of shock.
Page Ref: 1355
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.L. Analyze shock as it relates to perfusion. Describe the etiology of shock.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with shock.

3) A client who is taking beta-adrenergic blockers for angina is experiencing hypovolemic shock. Which collaborative intervention does the nurse anticipate being the priority for this client?
A) Administering analgesics for control of pain
B) Assessing the cause of bleeding
C) Providing replacement of volume
D) Establishing invasive cardiac monitoring
Answer: D
Explanation: A) Pain would be a consideration but would not be attended to as a first priority.
B) Assessing the cause of bleeding would also occur after establishing invasive cardiac monitoring.
C) Replacement of volume would occur after invasive cardiac monitoring is established.
D) Clients who take beta blockers may not present with tachycardia as an early indicator of shock. These individuals will require early invasive monitoring to avoid excessive or inadequate volume restoration.
Page Ref: 1357
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.L. Analyze shock as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with shock.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with shock.

4) The nurse has just completed the assessment of a client admitted with a gunshot wound to the femoral artery. Which is the priority problem for this client?

A) Insufficient body fluid

B) Inability to cope

C) Impaired breathing

D) Decreased cardiac output

Answer: D

Explanation: A) The client will most likely have insufficient body fluid; however, cardiac output is the first priority at this time.

B) There is not enough information to determine whether the client is experiencing the inability to cope.

C) There is not enough information to determine whether the client has problems breathing.

D) The client sustained a gunshot wound to the femoral artery, which would lead to significant bleeding and the risk of hypovolemic shock. The priority problem would be decreased cardiac output because of low blood volume.

Page Ref: 1365

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Diagnosis

Learning Outcome: 16.L. Analyze shock as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with shock.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with shock.

5) The nurse is administering albumin 5% to a client in shock. Which nursing action is appropriate when assessing this client?
A) Auscultate breath sounds for inspiratory stridor
B) Auscultate breath sounds for crackles
C) Auscultate breath sounds for hyperresonance
D) Auscultate for an absence of breath sounds in the lower lobes
Answer: B
Explanation: A) Stridor is auscultated with airway obstruction, not pulmonary edema.
B) Because albumin 5% is a volume expander and pulls fluid into the vascular space, circulatory overload is a serious complication. The nurse must monitor breath sounds; crackles will be heard with pulmonary congestion.
C) Hyperresonance is assessed by percussion, not auscultation.
D) An absence of breath sounds is heard with a pneumothorax, not with pulmonary edema.
Page Ref: 1360
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2 Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.L. Analyze shock as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with shock.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with shock.

6) The nurse is providing teaching about infusion of albumin 5% to a client recovering from hypovolemic shock. Which statement by the client indicates that teaching was effective?
A) "It's a protein that causes my kidneys to conserve fluid."
B) "It's a protein that pulls water into my blood vessels."
C) "It's a liquid that has electrolytes in it to pull water into my blood vessels."
D) "It's a super-concentrated salt solution that helps me conserve body fluid."
Answer: B
Explanation: A) Albumin 5% does not act on the kidneys.
B) Colloids are proteins or other large molecules that stay suspended in the blood for long periods because they are too large to easily cross membranes. They draw water molecules from the cells and tissues into the blood vessels through their ability to increase plasma oncotic pressure.
C) Crystalloids are intravenous (IV) solutions that contain electrolytes, not proteins, in concentrations resembling those of plasma. They are used to replace lost fluids and promote urine output.
D) Albumin 5% is not a concentrated saline solution.
Page Ref: 1360
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Evaluation
Learning Outcome: 16.L. Analyze shock as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with shock.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with shock.

7) A client is receiving intravenous nitroprusside (Nipride) for shock. Which adverse reactions will the nurse assess this client for when administering the infusion? **Select all that apply.**
A) Muscle spasms
B) Tachycardia
C) Confusion
D) Gastrointestinal bleeding
E) Disorientation
Answer: A, B, C, E
Explanation: A) Muscle spasms are signs of thiocyanate poisoning, which can occur if the infusion is longer than 72 hours.
B) Tachycardia is an adverse reaction that the nurse should report immediately to the healthcare provider.
C) Confusion is an adverse reaction that the nurse should report immediately to the healthcare provider.
D) Gastrointestinal bleeding is not an adverse effect of this medication.
E) Disorientation is a sign of thiocyanate poisoning, which can occur if the infusion is longer than 72 hours.
Page Ref: 1361
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment

Learning Outcome: 16.L. Analyze shock as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with shock.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with shock.

8) The nurse is caring for a client who was involved in a motor vehicle accident and has lost approximately 1,550 mL of blood. For which stage of shock should the nurse plan care for this client?
A) Initial
B) Compensatory
C) Progressive
D) Refractory
Answer: C
Explanation: A) Initial shock is the early stage in which the baroreceptors in the aortic arch and carotid sinus detect a sustained drop in MAP of less than 10 mmHg from normal levels. Circulating blood volume may decrease (usually by less than 500 mL), and this loss is not enough to cause serious effects in an adult client.
B) Compensatory shock in adults occurs when the arterial pressure falls 10 to 15 mmHg below normal levels, resulting in a 15—30% blood volume reduction (usually 1000 mL or greater).
C) Progressive, or decompensated, shock occurs after a sustained decrease in MAP of 20 mmHg or more below normal levels and a blood volume loss of 30—40% (1,500-2,000mL).
D) Refractory or irreversible shock is when generalized tissue anoxia and widespread cellular death occur. This stage is not responsive to any treatment.
Page Ref: 1353
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning

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Learning Outcome: 16.L. Analyze shock as it relates to perfusion. Describe the pathophysiology of shock.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with shock.

9) The nurse is caring for a client in progressive hemorrhagic shock. Which statement explains the physiology of this stage of shock?
A) It involves a sustained decrease of 10 mmHg of the client's mean arterial pressure (MAP).
B) It involves a blood loss of 25%.
C) It involves a change from aerobic to anaerobic metabolism.
D) It involves a decrease in hydrostatic pressure within the capillary, shifting fluid into the interstitial space.
Answer: C
Explanation: A) A decrease in MAP occurs in initial shock.
B) There is a 15 to 25% loss of blood in compensatory shock.
C) In decompensated or progressive hemorrhagic shock, there is a change from aerobic to anaerobic metabolism due to cellular hypoxia from decreased perfusion. This stage of shock occurs when there is sustained decrease of 20 mmHg or more of the client's MAP and a blood loss of 30-40%. The acid by-products of anaerobic metabolism cause an increase, not decrease, in hydrostatic pressure within the capillary, shifting fluid into the interstitial space.
D) Compensatory shock causes a decrease in hydrostatic pressure in the capillaries.
Page Ref: 1353
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.L. Analyze shock as it relates to perfusion. Describe the pathophysiology of shock.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with shock.

10) A client with hemophilia is at increased risk for which type of shock?
A) Cardiogenic shock
B) Hemorrhagic shock
C) Anaphylactic shock
D) Distributive shock
Answer: B
Explanation: A) The client is not at higher risk for cardiogenic shock.
B) Because clients with hemophilia have a decreased ability to form clots, they are at high risk for hemorrhagic shock.
C) Hemophilia does not increase the risk for anaphylactic shock.
D) Hemophilia does not increase the risk for distributive shock.
Page Ref: 1357
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.L. Analyze shock as it relates to perfusion. Compare the risk factors and prevention of shock.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with shock.

WwW.TeSM.Ws

11) Which type of shock is characterized by increased pulse and respirations, normal blood pressure, elevated body temperature, and warm and flushed skin?
A) Hypovolemic shock
B) Cardiogenic shock
C) Neurogenic shock
D) Septic shock
Answer: D
Explanation: A) In hypovolemic shock the skin will typically be pale and cool rather than warm and flushed.
B) In cardiogenic shock, the skin will typically be pale and cool rather than warm and flushed.
C) In neurogenic shock, the pulse will be slow and bounding rather than rapid.
D) Early septic shock is characterized by normal to slightly decreased blood pressure; increased pulse and respirations; warm, flushed skin; and chills, among other symptoms.
Page Ref: 1358
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.L. Analyze shock as it relates to perfusion. Identify the clinical manifestations of shock.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with shock.

12) For which reason should IV fluids be warmed to help resuscitate clients in shock?
A) Increase vasodilation
B) Prevent hypothermia
C) Prevent hyperthermia
D) Increase vasoconstriction
Answer: B
Explanation: A) Use of warm IV fluids does not cause vasodilation.
B) Using room-temperature fluids can cause hypothermia, which may hinder the effectiveness of treatment. Therefore, warmed IV fluids should be used to help resuscitate clients in shock.
C) Use of warm IV fluids does not prevent hyperthermia.
D) Use of warm IV fluids does not cause vasoconstriction.
Page Ref: 1365
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.L. Analyze shock as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with shock.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with shock.

13) A child with burns on 30% of the body goes into shock and needs CPR. Which step should the nurse take first based on pediatric advanced life support (PALS) guidelines?
A) Begin ventilations
B) Begin chest compressions
C) Obtain a defibrillator
D) Establish vascular access
Answer: B
Explanation: A) A second healthcare provider should begin ventilations with a bag and mask.
B) Based on PALS guidelines, the first step in providing life support to a child is to immediately begin chest compressions. This is the first step because no equipment is needed, so compressions can begin immediately.
C) A monitor and defibrillator should be obtained as the third step.
D) Establishing vascular access should be the fourth step.
Page Ref: 1363
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.L. Analyze shock as it relates to perfusion. Differentiate care of patients with shock across the lifespan.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with shock.

14) A 67-year-old client with a history of type 2 diabetes mellitus and chronic hypertension has a myocardial infarction. Which type of shock should the nurse be prepared to treat in this client?
A) Cardiogenic shock
B) Hypovolemic shock
C) Neurogenic shock
D) Septic shock
Answer: A
Explanation: A) Older adults who have a heart attack, especially those with a history of heart failure, diabetes, or hypertension, have an increased risk of cardiogenic shock. Therefore, the nurse should be monitoring the client for signs and symptoms of cardiogenic shock and be prepared to respond immediately to any warning signs of shock.
B) This client is not at risk for hypovolemic shock after an acute myocardial infarction.
C) This client is not at risk for neurogenic shock after a myocardial infarction.
D) This client is not at risk for septic shock after a myocardial infarction.
Page Ref: 1358, 1364
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.L. Analyze shock as it relates to perfusion. Differentiate care of patients with shock across the lifespan.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with shock.

Exemplar 16.M Stroke

1) While completing a health history with an older adult client, the nurse learns that the client experienced a transient ischemic attack (TIA) several months ago. Which outcome should the nurse consider for this client?
A) Is at risk for an ischemic thrombotic stroke
B) Will have minimal symptoms should a stroke occur
C) Will not experience a stroke in the future
D) Is at high risk for a hemorrhagic stroke
Answer: A
Explanation: A) TIAs are often warning signs of an ischemic thrombotic stroke.
B) There is no way to predict the symptoms the client will experience after a stroke.
C) One or many TIAs may precede a stroke, with the time between the attack and the stroke ranging from hours to months.
D) A hemorrhagic stroke is caused by the rupture of a cerebral blood vessel and is not related to a TIA.
Page Ref: 1369
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Evaluation
Learning Outcome: 16.M. Analyze stroke as it relates to perfusion. Describe the pathophysiology of each type of stroke.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with stroke.

2) While teaching a wellness class on the warning signs of stroke, a participant asks. "What's the most important thing for me to remember?" Which response should the nurse make?
A) "Be alert for sudden weakness or numbness."
B) "Know your family history."
C) "Keep a list of your medications."
D) "Call 911 if you notice a gradual onset of paralysis or confusion."
Answer: A
Explanation: A) Warning signs of stroke include sudden weakness, numbness, paralysis, loss of speech, confusion, dizziness, unsteadiness, and loss of balance–the key word is *sudden.*
B) A family history could be an indicator for a stroke however this information is not the most important for the participants to remember. .
C) A list of medications is not the most important thing for the client to remember.
D) Gradual onset of symptoms is not indicative of a stroke.
Page Ref: 1371
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.M. Analyze stroke as it relates to perfusion. Compare the risk factors and prevention of stroke.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with stroke.

3) The nurse is planning care for a client with a stroke. Which intervention would support the client's sensorimotor needs?
A) Encourage use of nonaffected arm to feed self, bathe, and dress.
B) Speak in normal conversational pattern and tones.
C) Provide complete care.
D) Talk loudly and distinctly.
Answer: A
Explanation: A) To address the client's alteration in sensory and motor statuses, the nurse should encourage the client to use the nonaffected arm to feed self, bathe, and dress.
B) Speaking in normal conversational patterns and tones may not be adequate when communicating with the client.
C) The nurse should not provide all care for the client.
D) The nurse should not talk loudly to the client but should articulate slower and face the client when speaking.
Page Ref: 1380
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.M. Analyze stroke as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with stroke.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with stroke.

4) A client diagnosed with a stroke is going to receive treatment with fibrinolytic therapy using the recombinant tissue plasminogen activator alteplase (rt-PA). Which information should the nurse include when performing medication teaching for the client's family?
A) Used to treat thrombotic and hemorrhagic strokes
B) Not associated with serious complications
C) Indicated if the stroke symptoms have occurred within the last 6 hours
D) Administered to break up existing clots and increase cerebral blood flow
Answer: D
Explanation: A) The treatment is only used with ischemic strokes.
B) Bleeding is a complication associated with the treatment, which may result in cerebral hemorrhage, causing extensive brain damage and disability.
C) The treatment can be used if the symptoms have occurred within the last 3 hours.
D) Thrombolytic therapy using rt-PA is used to dissolve the clot formed with a thrombotic stroke. Dissolving the clot reestablishes cerebral circulation.
Page Ref: 1376
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.M. Analyze stroke as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with stroke.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with stroke.

5) The nurse is instructing the spouse of a client with a stroke on how to do passive range-of-motion exercises to the affected limbs. Which rationale for this intervention will the nurse include in the teaching session?
A) Improve muscle strength
B) Maintain cardiopulmonary function
C) Improve endurance
D) Maintain joint flexibility
Answer: D
Explanation: A) Active range-of-motion exercises improve muscle strength.
B) Active range-of-motion exercises can help maintain cardiopulmonary functioning.
C) Active range-of-motion exercises improve endurance.
D) The nurse should instruct the spouse that the exercises will help with joint flexibility.
Page Ref: 1380
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.M. Analyze stroke as it relates to perfusion. Apply the nursing process in providing culturally competent care to an individual with stroke.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with stroke.

6) A client with a suspected transient ischemic attack (TIA) develops aphasia. Based on this data, the nurse plans care based on ischemia to which portion of the brain?
A) Anterior cerebral artery
B) Vertebral artery
C) Left hemisphere of the brain
D) Right hemisphere of the brain
Answer: C
Explanation: A) Ischemia of the anterior cerebral artery does not cause aphasia.
B) Ischemia of the vertebral artery does not cause aphasia.
C) Aphasia occurs due to ischemia of the left hemisphere.
D) Ischemia to the right hemisphere of the brain does not cause aphasia.
Page Ref: 1372
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Planning
Learning Outcome: 16.M. Analyze stroke as it relates to perfusion. Identify the clinical manifestations of stroke.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with stroke.

7) The nurse is teaching a class at the community center regarding the cultural and ethnic risk factors for stroke. Which statement should the nurse include in this presentation?

A) White Americans have an increased incidence of intracerebral hemorrhage.

B) Black Americans have almost twice the number of first-ever strokes compared with Whites.

C) Asian Americans are more likely to die following a stroke than Whites.

D) The prevalence of hypertension among Hispanics is the highest in the world.

Answer: B

Explanation: A) White Americans have half the number of first-ever strokes compared to Black Americans.

B) Black Americans have almost twice the number of first-ever strokes compared with White Americans.

C) There is no evidence that Asian Americans are more likely to die from a stroke than White Americans.

D) Black Americans have the highest rate of hypertension compared to other races/ethnicities.

Page Ref: 1371

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation

Learning Outcome: 16.M. Analyze stroke as it relates to perfusion. Compare the risk factors and prevention of stroke.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with stroke.

8) Which type of stroke occurs when the blood supply to a part of the brain is cut off by a thrombus, embolus, or stenosis?
A) Intracerebral stroke
B) Subarachnoid stroke
C) Hemorrhagic stroke
D) Ischemic stroke
Answer: D
Explanation: A) Intracerebral is a type of hemorrhagic stroke.
B) Subarachnoid is a type of hemorrhagic stroke.
C) Hemorrhagic stroke occurs when a blood vessel breaks open and spills blood into spaces surrounding neurons.
D) Strokes may be ischemic, occurring when the blood supply to a part of the brain is suddenly interrupted by a thrombus (blood clot), embolus (foreign matter traveling through the circulation), or stenosis (narrowing).
Page Ref: 1369
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 16.M. Analyze stroke as it relates to perfusion. Describe the etiology of each type of stroke.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with stroke.

9) After a stroke, sensory-perceptual changes increase the client's risk for which condition?
A) Aspiration
B) Injury
C) Bleeding
D) Infection
Answer: B
Explanation: A) Sensory-perceptual changes do not increase the risk for aspiration.
B) Strokes often alter the ability to integrate, interpret, and attend to sensory data. The client may experience deficits in vision, hearing, equilibrium, taste, and smell. The ability to perceive vibration, pain, warmth, cold, and pressure may be impaired, as may proprioception (the body's sense of its position). The loss of these sensory abilities increases the risk for injury.
C) Sensory-perceptual changes do not increase the risk for bleeding.
D) Sensory-perceptual changes do not increase the risk for infection.
Page Ref: 1372
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies:2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Diagnosis
Learning Outcome: 16.M. Analyze stroke as it relates to perfusion. Identify the clinical manifestations of stroke.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with stroke.

10) The medication clopidogrel is most commonly given during which stage of treatment for a stroke?
A) Stroke prevention
B) Acute care immediately after a stroke
C) Recovery care after a stroke
D) Rehabilitation after a stroke
Answer: A
Explanation: A) Antiplatelet and anticoagulant drugs, including aspirin, clopidogrel, dipyridamole, and ticlopidine, are often used as preventive drugs in clients with a history of previous transient ischemic attacks or stroke.
B) Recombinant tissue plasminogen activator alteplase is the gold standard for the treatment of acute ischemic stroke.
C) A variety of medications may be used during stroke recovery, based upon the deficits and residual symptoms.
D) The rehabilitation phase of treatment usually involves physical, occupational, and/or speech therapy rather than medication.
Page Ref: 1375
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.M. Analyze stroke as it relates to perfusion. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with stroke.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with stroke.

11) During a 6-month well-baby checkup, the mother reports that the infant seems to be sleeping more and does everything with the left hand. Which question should the nurse ask to assess for signs of stroke?
A) "Have you noticed your baby jerking any muscles of the face, arms, or legs?"
B) "Have you noticed your baby having trouble forming words?"
C) "Does your baby vomit frequently after feeding?"
D) "Does your baby frequently seem to lose her balance?"
Answer: A
Explanation: A) Stroke warning signs in infants include seizures, extreme sleepiness, and favoring the use of only one side of the body. Signs of seizure in neonates include repetitive facial movements, staring, apnea, and jerking of the muscles of the face, arms, or legs.
B) Questions related to forming words are not age appropriate, as most normal 6-month-old infants do not have the ability to form words.
C) The question related to vomiting is also not appropriate, as vomiting at this age is more frequently related to food intolerances/allergies or gastrointestinal problems rather than stroke.
D) Questions related to balance are not age-appropriate, as most normal 6-month-old infants do not have steady balance.
Page Ref: 1377
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe evidence-based practice to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Communicate information effectively; Listen openly and cooperatively. | Nursing Process: Assessment
Learning Outcome: 16.M. Analyze stroke as it relates to perfusion. Differentiate care of patients with stroke across the lifespan.
MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with stroke.

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12) The nurse is providing community health teaching on stroke in children and adolescents. Which risk factor for this population should the nurse identify?
A) Hypertension
B) Dysrhythmias
C) Arteriosclerosis
D) Head trauma
Answer: D
Explanation: A) Common causes of adult strokes such as hypertension are rare in children.
B) Common causes of adult strokes such as dysrhythmias are rare in children.
C) Common causes of adult strokes such as arteriosclerosis are rare in children.
D) Common causes of strokes in children and adolescents include congenital heart defects, sickle-cell disease, immune disorders, arterial diseases, abnormal blood clotting, trauma to the head or neck, and maternal history of infertility.
Page Ref: 1378
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 16.M. Analyze stroke as it relates to perfusion. Differentiate care of patients with stroke across the lifespan.

MNL LO: Demonstrate understanding of the concept of perfusion in the care of a patient with stroke.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 17 Perioperative Care

The Concept of Perioperative Care

1) The nurse is providing teaching to a client who is scheduled to undergo surgery in 2 weeks. Which topics should the nurse include that will prepare the client to help reduce complications during the postoperative phase? **Select all that apply.**
A) Maintaining a patent airway
B) Deep breathing and coughing
C) Caring for the surgical incision
D) Managing constipation
E) Managing pain
Answer: B, C, D, E
Explanation: A) Maintaining a patent airway is a nursing action that is performed during and after surgery; the client would not need client teaching about how to maintain a patent airway.
B) In the preoperative phase, when the client is alert and oriented, the nurse should focus teaching on deep breathing and coughing exercises.
C) In the preoperative phase, when the client is alert and oriented, the nurse should focus teaching on care of the surgical incision.
D) In the preoperative phase, when the client is alert and oriented, the nurse should focus teaching on managing constipation.
E) In the preoperative phase, when the client is alert and oriented, the nurse should focus teaching on managing pain.

Page Ref: 1394
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 17.3. Explain the process of preoperative nursing.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

2) The nurse is providing teaching to a client who is about to undergo surgery. When discussing whom the client can expect to see in the operating room suite, which individuals should the nurse include? **Select all that apply.**
A) Surgeon
B) Postoperative nurse
C) Circulating nurse
D) Anesthesiologist
E) Social worker
Answer: A, C, D
Explanation: A) The surgeon performs the procedure.
B) The postoperative nurse will provide care to the client after the surgery is completed.
C) The circulating nurse is a perioperative registered nurse who cares for the client during the surgical procedure.
D) The anesthesiologist provides the anesthesia during the surgery and continually monitors the client's physiologic status.
E) The social worker will not be in attendance during the procedure but may become involved in the client's care during the preoperative and postoperative phases.
Page Ref: 1388
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of health care team members. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 17.1. Summarize the scope of perioperative nursing.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

3) The postoperative nurse is planning care for a client recovering from major surgery. On which problems should the nurse focus to plan for this client's immediate care needs? **Select all that apply.**

A) Maintaining an airway
B) Managing the surgical wound
C) Ensuring an adequate cardiac rhythm
D) Preparing for discharge
E) Managing intravenous lines

Answer: A, B, C, E

Explanation: A) The client recovering from surgery may experience the effects of anesthesia which could compromise the airway. The head-tilt-chin-lift maneuver may need to be done to keep the airway open.

B) The client will have a surgical wound that will need to be monitored and reinforced until the surgeon performs the first dressing change.

C) Anesthesia may adversely affect the heart rhythm which will need to be monitored.

D) Planning for discharge is not an immediate need.

E) After surgery, the client will have infusion lines and possibly drains that will need to be monitored.

Page Ref: 1411

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 17.5. Explain the process of postoperative nursing.

MNL LO: Analyze the concept of perioperative care and its application to nursing care.

4) The nurse determines that a client in the postoperative phase of care can be transitioned to phase 2 of recovery. The client is able to take deep breaths and cough, is using oxygen to maintain a saturation of greater than 90%, is fully awake, has a systolic blood pressure that is 130 mmHg now but the preoperative systolic blood pressure was 100 mmHg, and is able to move all four extremities independently. Using the following scale, this client's Aldrete score is ________.

The Aldrete score:

Respiration
2 = Able to take deep breath and cough
1 = Dyspnea/shallow breathing
0 = Apnea

O_2 Saturation
2 = Maintains >92% on room air
1 = Needs O_2 inhalation to maintain O_2 saturation >90%
0 = Saturation <90% even with supplemental oxygen

Consciousness
2 = Fully awake
1 = Arousable on calling
0 = Not responding

Circulation
2 = BP 20% preop
1 = BP 20–49% preop
0 = BP 50% preop

Activity
2 = Able to move 4 extremities
1 = Able to move 2 extremities
0 = Able to move 0 extremities
Answer: 8
Explanation: The Aldrete system is designed to assess a client's transition from phase 1 recovery to phase 2 recovery, from discontinuation of anesthesia until return of protective reflexes and motor function. The criteria of respirations, oxygen saturation, consciousness, circulation, and activity are scored. The maximum score is 10. This client scores a 2 for respiration, a 1 for oxygen saturation, a 2 for consciousness, a 1 for circulation (roughly a 25% increase in blood pressure over preop BP, and a 2 for activity for a total of 8. Clients who score ≥8 are considered fit for transition to phase 2 recovery.
Page Ref: 1413
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 17.5. Explain the process of postoperative nursing.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

5) The nurse is reviewing the documentation from the intraoperative phase of a client's surgical procedure. Which information should the nurse anticipate finding on the intraoperative documentation? **Select all that apply.**
A) Pain assessment
B) Start and stop times of anesthesia
C) Medication review
D) Antibiotic infusion times
E) Start and stop times of the procedure
Answer: B, D, E
Explanation: A) The pain assessment is documented during both the preoperative and postoperative assessments.
B) Intraoperative documentation is to include documentation about specific times, such as the start and stop times of anesthesia.
C) Medication review is documented during both the preoperative and postoperative assessments.

D) Intraoperative documentation is to include documentation about specific times, such as antibiotic infusion times.
E) Intraoperative documentation is to include documentation about specific times, such as the start and stop times of the procedure.
Page Ref: 1407
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.B.4. Document and plan patient care in an electronic health record. | AACN Domains and Competencies:. 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality & Safety: Carefully maintain and use electronic and/or written health records. | Nursing Process: Implementation
Learning Outcome: 17.4. Explain the process of intraoperative nursing.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

6) The nurse is preparing a client for emergency surgery to repair liver and colon lacerations caused by a motor vehicle crash. Which information about this type of surgery will the nurse use to guide the client's care? **Select all that apply.**
A) An organ is going to be removed.
B) This is an emergency surgery.
C) The client will be hospitalized longer.
D) The client is at risk for blood loss.
E) The client is at risk for hypothermia.
Answer: B, C, D, E
Explanation: A) The client is having surgery to repair lacerations. No organ is identified for removal.
B) Emergency surgery is performed when a condition is life-threatening. Surgery to control internal hemorrhage from lacerations is an example of emergency surgery.
C) An open procedure usually requires a longer hospital stay.
D) Open procedures place the client at a higher risk for blood loss.
E) Larger incisions place the client at a higher risk for complications, such as hypothermia and surgical site infections (SSIs).
Page Ref: 1398-1399
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 17.4. Explain the process of intraoperative nursing.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

7) While receiving report from the operating room, the nurse learns that a client's surgical wound after gallbladder removal is classified as III. What does this classification tell the nurse? **Select all that apply.**
A) The alimentary tract was not entered.
B) The wound is necrotic and infected.
C) Gallbladder contents spilled into the surgical site.
D) A break in sterility occurred during the surgery.
E) The alimentary, respiratory, genital, or urinary tract was entered.
Answer: C, D
Explanation: A) An incision is classified as I–clean if the alimentary, respiratory, genital, and urinary tract are not entered.
B) An incision is classified as IV–dirty, infected if the wound is necrotic and infected.
C) An incision is classified as III–contaminated if gross spillage from the GI tract occurred.
D) An incision is classified as III if a major break in sterile technique occurred.
E) An incision is classified as II–lean contaminated if there are no signs of infection but the alimentary, respiratory, genital, or urinary tracts were entered.
Page Ref: 1407
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 17.4. Explain the process of intraoperative nursing.

MNL LO: Analyze the concept of perioperative care and its application to nursing care.

8) The nurse is preparing an older adult client for surgery. On which topics should the nurse focus when preparing this client's preoperative teaching? **Select all that apply.**
A) Level of hearing
B) Amount of anesthesia needed during surgery
C) Teaching on deep breathing and coughing
D) Plans for discharge care
E) Actions to prevent pressure injuries
Answer: A, C, D, E
Explanation: A) For the older client, make sure the client can hear the information to be presented or provide information through alternative means.
B) Clients do not need teaching related to intraoperative anesthesia amounts.
C) Deep breathing and coughing assist in the prevention of pneumonia and other respiratory conditions related to surgery, and deep breathing and coughing education should start in the preoperative phase.
D) The older client is going to need assistance once discharged and should have the necessary medical equipment such as walkers and raised toilet seats, assistance with transportation, or extended care.
E) The older client could be at risk for pressure injuries formation because of poor nutritional status, diabetes, cardiovascular illness, or a history of steroid use.
Page Ref: 1415
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 17.6. Differentiate perioperative considerations throughout the lifespan.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

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9) Which measurement is obtained by a prothrombin time (PT) test?
A) Time required for the client's blood to clot
B) Time required for the client's plasma to clot
C) Time required for platelets to effectively stop bleeding
D) Time required for a surgical procedure
Answer: B
Explanation: A) A partial thromboplastin time (PTT) test measures the time required for the client's blood to clot.
B) A prothrombin time (PT) test measures the time required for the client's plasma to clot.
C) A bleeding time test measures the time required for platelets to effectively stop bleeding.
D) No diagnostic test measures the time required for a surgical procedure.
Page Ref: 1389
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 17.1. Summarize the scope of perioperative nursing.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

10) Which drug may be used to treat nausea and vomiting associated with operative procedures?
A) Metoclopramide
B) Acetaminophen
C) Midazolam
D) Fentanyl
Answer: A
Explanation: A) An antiemetic such as metoclopramide may be used to treat nausea and vomiting associated with operative procedures.
B) A nonopioid analgesic such as acetaminophen provides temporary analgesia for mild to moderate pain.
C) An anxiolytic such as midazolam is a relaxant.
D) An opioid analgesic such as fentanyl controls moderate to severe pain but does not alter the pain threshold.
Page Ref: 1392
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 17.1. Summarize the scope of perioperative nursing.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

11) Which statement explains a characteristic of assessment in perioperative care?
A) It is primarily a component of preoperative care.
B) It is used most often during the intraoperative process.
C) It primarily is involved in evaluating clients during postoperative care.
D) It is involved in every part of the perioperative process.
Answer: D
Explanation: A) Assessment is a part of all phases of the operative experience.
B) Assessment is a part of all phases of the surgical experience.
C) Assessment is a part of all phases of the operative experience.
D) Assessment is the most significant concept during the perioperative process and encompasses most of the other concepts.
Page Ref: 1388, 1393
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 17.2. Outline the relationship between perioperative care and other concepts.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

12) Which statement best describes the vital signs the nurse collects during the preoperative phase?

A) They are the only vital signs collected during the perioperative period.
B) When later vital signs are taken, they are compared against the preoperative set.
C) Generally preoperative vital signs are only relevant during the intraoperative process.
D) These are not essential and may be omitted for emergency surgeries.
Answer: B
Explanation: A) Preoperative vital signs are not the only vital signs collected during the perioperative period.
B) Vital signs, including blood pressure, pulse, respiration, and oxygen saturation, should be taken throughout the perioperative period, with the baseline vital signs being obtained during the preoperative phase. Later vital signs will be compared against this baseline.
C) Vital signs are relevant through the perioperative period as a baseline.
D) Vital signs are important to record for any client.
Page Ref: 1395
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 17.3. Explain the process of preoperative nursing.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

13) At which time should a client be monitored during the intraoperative phase?
A) Every 5 minutes
B) Every 30 minutes
C) Constantly
D) Occasionally
Answer: C
Explanation: A) Monitoring the client every 5 minutes could miss an important change in the client's status that could result in client harm or adverse complications.
B) Monitoring the client every 30 minutes could miss an important change in the client's status that could result in client harm or adverse complications.
C) Constant monitoring of both the surgical environment and the client is necessary to ensure client safety.
D) Monitoring the client occasionally could miss an important change in the client's status that could result in client harm or adverse complications.
Page Ref: 1398
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 17.4. Explain the process of intraoperative nursing.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

14) A client with terminal cancer is undergoing surgery to partially remove a tumor that is pressing on a nerve and causing pain. In which way should this surgery be classified?
A) Reconstructive
B) Diagnostic
C) Palliative
D) Emergency
Answer: C
Explanation: A) Reconstructive surgery is to restore lost or reduced appearance or function.
B) A diagnostic procedure would be conducted to determine or confirm a diagnosis.
C) Palliative surgery may be performed to alleviate pain or symptoms associated with a disease, and so this client's surgery, because it involves partially removing a tumor causing severe pain, is most illustrative of palliative surgery.
D) Emergency surgery is to save life or limb.
Page Ref: 1398
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 17.4. Explain the process of intraoperative nursing.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

15) Which situation demands that all perioperative staff cover their bodies with lead shields?
A) The surgical team uses a bipolar handpiece to cauterize a client's tissue.
B) The surgical team uses a class 3 laser to cut a client's kidney stone.
C) The surgical team uses a pneumatic tourniquet to cut off circulation to a client's hand.
D) The surgical team uses radiology to take intraoperative photos.
Answer: D
Explanation: A) A bipolar handpiece is not a radiologic procedure.
B) A laser is not a radiologic procedure.
C) A pneumatic tourniquet is not a radiologic procedure.
D) When radiology is used, perioperative staff must make sure lead shields cover their bodies, including women's ovaries and men's testicles, because radiation can cause sterility. Staff should also wear a neck shield to protect the thyroid gland.
Page Ref: 1400
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 5.3 Contribute to a culture of provider and work environment safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 17.4. Explain the process of intraoperative nursing.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

16) A client presents with decreased blood volume, hypotension, tachycardia, and tachypnea during surgery. Which intraoperative complication most likely occurred?

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A) Hypovolemia
B) Hypervolemia
C) Hypokalemia
D) Hypernatremia
Answer: A
Explanation: A) Hypovolemia is an intraoperative complication that presents with decreased fluid (blood) volume, decreased blood pressure, decreased urine output, increased heart rate, and increased respiratory rate. This client is presenting with decreased blood volume, low blood pressure, and fast heart and respiratory rates, and so is probably hypovolemic.
B) Hypervolemia would present with increased fluid volume and blood pressure.
C) This client is not presenting with any of the signs of hypokalemia.
D) This client is not presenting with any of the signs of hypernatremia.
Page Ref: 1408
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 17.4. Explain the process of intraoperative nursing.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

17) The nurse was involved in the perioperative care of a preterm infant requiring cardiothoracic surgery. The infant has now been moved to the NICU. In which way should the nurse change the focus of the assessment in the postoperative phase?
A) The nurse should assess the client as preterm.
B) The nurse should assess the client's respiratory status.
C) The nurse should assess the client's glucose levels.
D) The nurse should assess the parents' coping mechanisms.
Answer: D
Explanation: A) Assessing the client as preterm happens during preoperative care.
B) Assessing the client's respiratory status is given special care during the transition into intraoperative care.
C) Assessing and regulating the client's glucose levels happens during intraoperative care.
D) The postoperative infant client will most often be transferred to, and cared for in, the neonatal intensive care unit (NICU) at the facility at which the infant had the procedure. At this stage, the nurse should focus largely on support for the parents. Assessment of parents' grief, guilt, anxiety, and coping mechanisms is necessary so that the nurse may better assist the infant in receiving the necessary care required from the parents.
Page Ref: 1414
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 17.6. Differentiate perioperative considerations throughout the lifespan.
MNL LO: Analyze the concept of perioperative care and its application to nursing care.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 18 Sensory Perception

The Concept of Sensory Perception

1) Which components of the sensory process will the nurse focus on when assessing a client?
A) Stimulus and receptor
B) Kinesthesia and stereognosis
C) Visual and auditory
D) Reception and perception
Answer: D
Explanation: A) Stimuli and receptors are aspects of how sensory information is received and perceived.
B) Kinesthesia is awareness of the position and movement of body parts, and stereognosis is the ability to perceive and understand an object through touch.
C) Visual and auditory stimuli are parts of how the body senses the external world.
D) The sensory process involves two components: reception and perception. Sensory reception is the process of receiving stimuli or data. Sensory perception involves the conscious organization and translation of the data or stimuli into meaningful information.
Page Ref: 1420
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 18.1. Analyze the physiology of sensory perception in the body.
MNL LO: Analyze the concept of sensory perception and its application to nursing care.

2) The nurse is selecting sensory aids for a client with deficits in hearing and sight. Which aid would address both sensory deficits?
A) Adequate room lighting with night lights
B) Flashing alarm clock with large numbers
C) Amplified telephone
D) Large-print reading material
Answer: B
Explanation: A) Adequate room lighting with night lights help with a sight deficit but not a hearing deficit.
B) A flashing alarm clock would be helpful for a client with a hearing deficit, and a clock with large numbers would be helpful for a client with a sight deficit.
C) An amplified telephone helps with a hearing deficit but not a sight deficit.
D) Large-print reading material help with a sight deficit but not a hearing deficit.
Page Ref: 1440
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 18.6. Analyze independent interventions nurses can implement for patients with alterations in sensory perception.
MNL LO: Analyze the concept of sensory perception and its application to nursing care.

3) The nurse is planning care for an older adult client diagnosed with age-related macular degeneration (AMD) that is nonexudative. Which therapies should the nurse anticipate for this client? **Select all that apply.**

A) Laser surgery
B) Eye patches
C) Antioxidants
D) Eyedrops
E) Zinc

Answer: C, E

Explanation: A) Laser surgery is used to treat wet macular degeneration.
B) Eye patches may be used after laser surgery but are not part of the initial treatment for the disorder.
C) High-dose antioxidants are the treatments of choice for early-to-intermediate dry AMD.
D) Eyedrops may be used after laser surgery but are not part of the initial treatment for the disorder.
E) Zinc is a treatment of choice for early-to-intermediate dry AMD.

Page Ref: 1422
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 18.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in sensory perception.
MNL LO: Analyze the concept of sensory perception and its application to nursing care.

4) A client tells the nurse about having increasing difficulty seeing the print while reading a newspaper. Which tool should the nurse select to assess this client?
A) Rosenbaum eye chart
B) Penlight
C) Cover-uncover test
D) Snellen eye chart
Answer: A
Explanation: A) The Rosenbaum eye chart is used to test for near or reading vision.
B) A penlight is used to test extraocular movements and pupillary response.
C) The cover-uncover test is used to assess for eye muscle strength.
D) The Snellen chart is used to test far or distant vision.
Page Ref: 1428
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.5. Differentiate common assessment procedures and tests used to examine sensory perception.
MNL LO: Analyze the concept of sensory perception and its application to nursing care.

5) Which diagnostic test should the nurse use to assess hearing in an infant?
A) Otoacoustic emissions test

B) Weber test
C) Rinne test
D) Whisper test
Answer: A
Explanation: A) The otoacoustic emissions test uses an earphone and microphone to play sounds into the ear. Failure to detect an echo indicates hearing loss.
B) The Weber test assesses bone and air conduction with the use of a tuning fork.
C) The Rinne test assesses bone and air conduction with the use of a tuning fork.
D) The whisper test provides a rough estimate of hearing loss. All three of these other tests involve active participation from the client.
Page Ref: 1395
Cognitive Level: Remembering
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.5. Differentiate common assessment procedures and tests used to examine sensory perception.
MNL LO: Analyze the concept of sensory perception and its application to nursing care.

6) The nurse is providing teaching on the recommended hearing tests for older adults. Which information should be included in this teaching?

A) Schedule an annual hearing test until the age of 50 and then have a test every 6 months.

B) Annual screenings are recommended for adults with diabetes.

C) For individuals without comorbidities, hearing exams should be repeated every 1-3 years for ages 55-64, and every 1-2 years for ages 65 and above.

D) Have a hearing test every 10 years until age 50 and then every 3 years.

Answer: D

Explanation: A) A biannual or annual hearing test is not necessary for this age group.

B) Annual screenings for vision are recommended for adults with diabetes.

C) For individuals without comorbidities, eye exams should be repeated every 1-3 years for ages 55-64, and every 1- years for ages 65 and above.

D) Adults should be screened for hearing at least every 10 years until the age of 50 and then every 3 years.

Page Ref: 1427

Cognitive Level: Applying

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 18.8. Differentiate considerations related to the assessment and care of patients with alterations in sensory perception throughout the lifespan.

MNL LO: Analyze the concept of sensory perception and its application to nursing care.

7) The nurse is conducting a prenatal assessment on a client. Which finding indicates a risk of sensory impairment in the unborn child?

A) Lack of immunity to rubella
B) History of otitis media
C) Immunity to varicella
D) Brief case of moderate conjunctivitis

Answer: A

Explanation: A) Maternal infection with rubella during pregnancy can cause vision impairment in newborns. Thus, lack of immunity to rubella indicates an increased risk of sensory impairment in the newborn.

B) Sensory deficits resulting from maternal otitis media would not be hereditary.

C) Immunity to varicella is a desirable trait that reduces a mother's chance of illness during pregnancy, thus lessening the likelihood of harm to the newborn.

D) Conjunctivitis, or pink eye, is an infection that usually clears up on its own and is not congenital.

Page Ref: 1423

Cognitive Level: Applying

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 18.8. Differentiate considerations related to the assessment and care of patients with alterations in sensory perception throughout the lifespan.

MNL LO: Analyze the concept of sensory perception and its application to nursing care.

8) A client is experiencing visual overstimulation. Which action should the nurse take immediately to reduce this client's visual sensory overload?

A) Suggest the client wear sunglasses that block UVA rays only.

B) Reduce the amount of light in the room by lowering shades and turning off overhead lights.

C) Provide the client with large-print reading materials.

D) Encourage the patient to employ relaxation techniques to reduce anxiety and stress.

Answer: B

Explanation: A) Dark glasses that block both UVA and UVB rays should be used.

B) For clients who are at risk of overstimulation, nurses should assist with reducing the number and types of environmental stimuli. Appropriate measures for addressing visual overstimulation include lowering the shades and turning off overhead lights.

C) Large-print reading materials would be helpful for a client with visual impairment but not a client who is experiencing visual sensory overload.

D) Relaxation techniques would be good for the client to employ but would require teaching for the client to properly implement them.

Page Ref: 1439

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 18.6. Analyze independent interventions nurses can implement for patients with alterations in sensory perception.

MNL LO: Analyze the concept of sensory perception and its application to nursing care.

9) The nurse is caring for a client with a genetic nerve disorder who has difficulty when attempting to move the tongue. The nurse recognizes that this may indicate a deficit in the functioning of which cranial nerve?
A) XII
B) XI
C) VIII
D) VI
Answer: A
Explanation: A) The movement of the tongue for speech and swallowing is controlled by cranial nerve (CN) XII, hypoglossal.
B) XI CN (accessory) controls the movement of head and neck as well as proprioception.
C) CN VIII (acoustic/vestibulocochlear) controls hearing and the sense of balance.
D) CN VI (abducens) controls eyeball movement and moves eye laterally.
Page Ref: 1420
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.3. Outline the relationship between sensory perception and other concepts.
MNL LO: Analyze the concept of sensory perception and its application to nursing care.

10) Which nursing action is most appropriate when communicating with a client who has a hearing deficit?

A) Drawing out the articulation of words with extra emphasis in order for the client to understand

B) Using shorter phrases, which tend to be easier to understand than longer ones

C) Varying the volume of voice, which is easier to understand than one consistent volume

D) Writing ideas or pantomiming as appropriate in order for the client to understand

Answer: D

Explanation: A) The nurse should not overarticulate words because it makes it more difficult to understand for the client with a hearing deficit.

B) The nurse should not use short phrases because it makes it more difficult to understand for the client with a hearing deficit.

C) The nurse should not vary the volume of voice because it makes it more difficult to understand for the client with a hearing deficit.

D) Writing ideas and pantomiming as appropriate are acceptable forms of communication for a client who has a hearing deficit.

Page Ref: 1440

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

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Learning Outcome: 18.6. Analyze independent interventions nurses can implement for patients with alterations in sensory perception.

MNL LO: Analyze the concept of sensory perception and its application to nursing care.

11) In which way should the nurse describe vertigo?
A) Involuntary rapid eye movements
B) A feeling of rotation or imbalance
C) An infection of the vestibular nerve
D) Impaired olfaction
Answer: B
Explanation: A) Nystagmus is involuntary rapid eye movements.
B) Vertigo is a feeling of rotation or imbalance.
C) Vestibular neuritis is an infection of the vestibular nerve that is a common cause of vertigo.
D) Impaired olfaction, or impaired sense of smell, has nothing to do with vertigo.
Page Ref: 1421
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.2. Differentiate alterations in sensory perception.
MNL LO: Analyze the concept of sensory perception and its application to nursing care.

12) Where does perception, or the awareness and interpretation of stimuli, take place?
A) The brain
B) The nerve receptors
C) The peripheral nervous system
D) The impulses
Answer: A
Explanation: A) Perception, or awareness and interpretation of stimuli, takes place in the brain.
B) The nerve receptors convert stimuli to impulses that travel along nerve pathways to the spinal cord or directly to the brain.
C) Perception does not take place in the peripheral nervous system.
D) Perception does not take place within the impulses.
Page Ref: 1419
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.1. Analyze the physiology of sensory perception in the body.
MNL LO: Analyze the concept of sensory perception and its application to nursing care.

13) Which assessment finding is a characteristic of achromatopsia?
A) Perceive only the secondary colors of purple, orange, and green.
B) Perceive only the primary colors of red, blue, and yellow.
C) Perceive some colors as indistinguishable from other colors.
D) Perceive only shades of gray and no colors.
Answer: D
Explanation: A) There is no type of color blindness where only the secondary colors are perceived.
B) Less common color blindness is the inability to distinguish between blue and yellow. Many people with the blue-yellow variant also have problems distinguishing between green and red.
C) Achromatopsia is not the perceiving of some colors as indistinguishable from other colors.
D) Achromatopsia is a rare form of color blindness in which the individual cannot distinguish any color at all and sees only shades of gray.
Page Ref: 1421
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.2. Differentiate alterations in sensory perception.
MNL LO: Analyze the concept of sensory perception and its application to nursing care.

Exemplar 18.A Hearing Impairment

1) The nurse suspects that an older adult client has a hearing disorder; however, the client denies not being able to hear, and the family thinks the client is just becoming more absent minded with age. Which initial action by the nurse to assess the client's hearing is appropriate?
A) Use an otoscope to visualize the inner ear.
B) Schedule a Weber and Rinne test.
C) Confront the client with the suspicion.
D) Observe the client's interaction with family.
Answer: D
Explanation: A) The use of an otoscope may be a part of an assessment but will not yield the immediate information that simple observation would.
B) The Weber and Rinne test may be a part of an assessment but will not yield the immediate information that simple observation would.
C) The client has already denied having a hearing problem, so confronting the client with the nurse's suspicion will probably only alienate the client from the nurse.
D) The most telling of these options would be to observe the client's interactions with family. The nurse should assess for frequent requests to repeat, inattention to conversation, turning one ear to the conversation, and lip-reading.
Page Ref: 1451
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.A. Analyze hearing impairment as it relates to sensory perception. Differentiate considerations for care of patients with hearing impairment across the lifespan.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a hearing impairment.

2) The nurse is providing teaching to a young adult client who is occasionally exposed to loud explosions on the job site. Which statement indicates the client understands the effect of loud noise on hearing?
A) "If my hearing is damaged on the job, I can have surgery to fix it."
B) "Hearing loss from exposure to loud noises actually has a genetic component."
C) "Damage to the ear from loud noises can cause permanent hearing loss."
D) "Hearing loss attributed to loud noises is normally reversible, especially in younger people."
Answer: C
Explanation: A) With sensorineural hearing loss, the only hope for restoring sound perception might be a cochlear implant; however, this surgery is not appropriate for all cases of sensorineural hearing loss, and even if a client is an ideal candidate, implants aren't always successful.
B) Hearing loss from loud noises has no genetic component.
C) Hearing loss attributed to loud noises can be profound and is often permanent, regardless of a person's age.
D) Hearing loss attributed to loud noises can be profound and is often permanent, regardless of a person's age.
Page Ref: 1446
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.A. Analyze hearing impairment as it relates to sensory perception. Identify the clinical manifestations of hearing impairment.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a hearing impairment.

3) Which decibel level can cause mild hearing loss?
A) 16-40 dB
B) 41-70 dB
C) 71-90 dB
D) 91+ dB
Answer: A
Explanation: A) 16-40 dB is mild hearing loss, at which some speech sounds are difficult to perceive.
B) 41-70 dB is moderate hearing loss, at which most normal conversational sounds are missed.
C) 71-90 dB is severe hearing loss, at which speech sounds cannot be heard at a normal conversational level.
D) 91+ dB is profound hearing loss and constitutes legal deafness.
Page Ref: 1445
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.A. Analyze hearing impairment as it relates to sensory perception. Describe the pathophysiology of hearing impairment.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a hearing impairment.

4) The nurse is identifying problems appropriate for a client with severe symptoms of tinnitus, vertigo, sensorineural hearing deficit, nausea, and vomiting. Which problem would be the lowest priority for this client?
A) Impaired verbal communication
B) Social isolation
C) Nausea and vomiting
D) Risk for injury
Answer: C
Explanation: A) Impaired verbal communication would be a problem of high priority.
B) Social isolation would be a problem of high priority.
C) Nausea and vomiting would be a problem for a client who has tinnitus, vertigo, and nausea; however, the greater priorities for this client would be safety related to falls, ensuring effective communication, and ensuring that the client does not become socially isolated.
D) Risk for injury would be the priority problem for the client.
Page Ref: 1451
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 18.A. Analyze hearing impairment as it relates to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hearing impairment.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a hearing impairment.

5) Which client should the nurse identify as having the greatest risk for hearing loss?
A) Construction worker who typically works in urban centers
B) Adolescent who occasionally listens to loud music on headphones
C) Teacher who works at a large high school
D) Lawyer who enjoys snowmobiling once a year
Answer: A
Explanation: A) The construction worker is likely to have the greatest risk for hearing loss because the client's occupation and typical work environment probably involve sustained exposure to very loud noises.
B) An adolescent who occasionally listens to loud music on headphones is also at risk for hearing loss, but the exposure to loud sounds is only occasional.
C) The teacher working at a large high school works in a noisy environment but is probably not typically exposed to sounds louder than the human voice.
D) Snowmobiles can be loud enough to present a risk for hearing loss, but the lawyer's exposure to them is only once a year.
Page Ref: 1446
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.A. Analyze hearing impairment as it relates to sensory perception. Compare the risk factors for and prevention of hearing impairment.

MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a hearing impairment.

6) The nurse is evaluating the care received by a client who has a hearing deficit. Which statement indicates that the client is effectively addressing variables that may lead to social isolation?
A) "I ask others to face me when they talk because I can hear them better."
B) "I keep the television volume raised to a high level."
C) "I don't use my hearing aid unless someone seems to need to talk to me."
D) "I might use the hearing aid when I go shopping."
Answer: A
Explanation: A) Evidence that the client is effectively addressing variables that may lead to social isolation would include the client's account of asking others to face them when talking. This indicates that the client is taking an active role in improving communication with others.
B) Listening to a loud television at all times is not conducive to good communication.
C) A reluctance to use an assistive device unless necessary does not encourage social interaction.
D) Using an assistive device when shopping does not encourage social interaction.
Page Ref: 1450
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 18.A. Analyze hearing impairment as it relates to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hearing impairment.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a hearing impairment.

7) Which strategy for communication enhancement incorporates the use of shapes?
A) Sign language
B) Oral approach
C) Total communication
D) Cued speech
Answer: D
Explanation: A) Sign language use signs, not shapes.
B) An oral approach involves only spoken communication and avoids the use of formal signs.
C) Total communication use signs, not shapes.
D) Cued speech incorporates the use of shapes.
Page Ref: 1450
Cognitive Level: Remembering
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.A. Analyze hearing impairment as it relates to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hearing impairment.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a hearing impairment.

8) The school nurse is identifying students who may have hearing loss. Which student would the nurse be most concerned about?
A) A child who startles easily at loud noises
B) A child who gets annoyed when things like televisions are too loud
C) A child who cannot follow conversations in the hallways between classes or in the cafeteria
D) A child who likes to listen to music on earbuds
Answer: C
Explanation: A) A child not startling at loud noises would be a sign of hearing loss.
B) A child who gets annoyed when electronic devices are too loud is behaving normally.
C) The child who cannot follow conversations in the hallways between classes or in the cafeteria appears to be having trouble understanding speech when background noise is present, which is a sign that the child may require further evaluation for hearing loss.
D) A child who likes to listen to music on earbuds is behaving normally.
Page Ref: 1450
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.A. Analyze hearing impairment as it relates to sensory perception. Differentiate considerations for care of patients with hearing impairment across the lifespan.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a hearing impairment.

9) The nurse is caring for a client who is receiving IV tobramycin for the treatment of a respiratory infection. Which teaching should the nurse provide to the client?
A) Understand the actions and drug interactions of aminoglycosides.
B) Self-monitor for hearing loss.
C) Use total communication.
D) Understand cued speech.
Answer: B
Explanation: A) It is not important for the client to understand the actions and drug interactions of the group of drugs to which tobramycin belongs.
B) Tobramycin, an aminoglycoside antibiotic, is used in the treatment of advanced bacterial infections and for the treatment of tuberculosis. A potential serious adverse effect of this class of medication is ototoxicity, affecting the client's hearing. The nurse should plan on teaching the client how to self-monitor for hearing loss.
C) Total communication is an approach to enhancing communication with clients who have a hearing deficit.
D) Cued speech is an approach to enhancing communication with clients who have a hearing deficit.
Page Ref: 1447
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.A. Analyze hearing impairment as it relates to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hearing impairment.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a hearing impairment.

10) The nurse is caring for several clients who are experiencing hearing loss. Of these clients, which is the best candidate for a cochlear implant?
A) A client with a perforated tympanic membrane
B) A client with sensorineural hearing loss from long-term exposure to loud noise
C) A client with an obstruction of the external ear canal
D) A client with a tumor of the middle ear
Answer: B
Explanation: A) Clients with a perforated tympanic membrane has a problem that leads to conductive hearing loss, which would not be treated with a cochlear implant.
B) For the client with a sensorineural hearing loss, a cochlear implant may be the only hope for restoring sound perception.
C) An obstruction of the external ear canal can lead to conductive hearing loss, which would not be treated with a cochlear implant.
D) A tumor of the middle ear can lead to conductive hearing loss, which would not be treated with a cochlear implant.
Page Ref: 1447
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.A. Analyze hearing impairment as it relates to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hearing impairment.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a hearing impairment.

11) Which finding indicates to the nurse that a client has a conductive hearing loss?
A) Loss of hearing to be the same at all frequencies
B) Loss of hearing to primarily involve the upper frequencies
C) Loss of hearing to primarily involve the middle frequencies
D) Loss of hearing to primarily involve the lower frequencies
Answer: A
Explanation: A) Conductive hearing loss involves an equal loss of hearing at all frequencies.
B) Sensorineural hearing loss typically affects the ability to hear high-frequency tones.
C) There is not a type of hearing loss that involves the middle frequencies.
D) There is not a type of hearing loss that involves the lower frequencies.
Page Ref: 1447
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.A. Analyze hearing impairment as it relates to sensory perception. Identify the clinical manifestations of hearing impairment.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a hearing impairment.

12) In which way would the nurse describe conductive hearing loss?
A) Degeneration of the hair cells of the cochlea

B) Damage to the hair cells of the organ of Corti
C) Disruption of the transmission of sound from the external auditory meatus to the inner ear
D) Decrease or distortion in the ability of the inner ear to receive and interpret auditory stimuli
Answer: C
Explanation: A) Degeneration of the hair cells of the cochlea is involved in progressive sensorineural hearing loss with aging, called presbycusis.
B) Damage to the hair cells of the organ of Corti is a significant cause of sensorineural hearing deficit.
C) Conductive hearing loss is any disruption of the transmission of sound from the external auditory meatus to the inner ear.
D) Sensorineural hearing loss is a decrease or distortion in the ability of the inner ear to receive and interpret auditory stimuli.
Page Ref: 1447
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.A. Analyze hearing impairment as it relates to sensory perception. Describe the etiology of hearing impairment.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a hearing impairment.

13) In which way would the nurse describe tinnitus?
A) A ringing sound accompanying perception of high-frequency tones
B) Auditory perception from visual stimuli
C) Lack of auditory perception of external auditory stimuli
D) Auditory perception without external auditory stimuli
Answer: D
Explanation: A) Tinnitus would not be ringing accompanying the perception of high-frequency tones because such a perception would involve external auditory stimuli.
B) Tinnitus does not involve perception of visual stimuli as auditory.
C) Lack of auditory perception of external auditory stimuli is lack of hearing.
D) Tinnitus is the perception of sound or noise in the ears without stimulus from the environment. The sound may be steady, intermittent, or pulsatile and is often described as a buzzing, roaring, or ringing.
Page Ref: 1447
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.A. Analyze hearing impairment as it relates to sensory perception. Identify the clinical manifestations of hearing impairment.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a hearing impairment.

Exemplar 18.B Diseases of the Eye

1) After being diagnosed with cataracts, a client believes the right eye has a cataract but not the left eye, as there are no vision changes with the left eye. Which response by the nurse is accurate?
A) "Only your doctor can tell if you have a cataract in your left eye."
B) "Cataracts develop at different rates, so one eye may be more affected than the other."
C) "The changes being confined to one eye indicate a less severe cataract."
D) "Surgery is still necessary for both eyes."
Answer: B
Explanation: A) The nurse should not tell the client that the healthcare provider is the only one who can tell if the client has a cataract in the left eye.
B) The nurse should respond that cataracts tend to occur in both eyes and develop at different rates, and one cataract generally matures more rapidly than the other.
C) The lack of vision changes in the left eye does not necessarily indicate the severity of the condition.
D) Surgery might not be necessary for either eye.
Page Ref: 1455
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Identify the clinical manifestations of selected diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

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2) Which assessment finding supports the nurse's conclusion that a client is at risk for cataracts?
A) Age 75 years
B) Hypertension
C) Moderate alcohol use
D) Smoker
Answer: A
Explanation: A) Age is the greatest single risk factor for cataracts.
B) Hypertension is not a risk factor for cataracts.
C) Moderate alcohol use is not a risk factor for cataracts.
D) Being a smoker would indicate such a predisposition, but this is still not as great a risk factor as the client's age.
Page Ref: 1453
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Compare the risk factors for and prevention of selected diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

3) The nurse is caring for several pediatric clients who are affected by cataracts. Of these clients, which is the most obvious candidate for surgical removal of the cataract?
A) Two-month-old infant who is asymptomatic
B) Six-month-old infant with difficulty noticing toys or faces
C) Three-month-old infant with diminished reaction to bright light
D) One-month-old infant with no reaction to bright light and failure to notice toys or faces
Answer: D
Explanation: A) The asymptomatic 2-month-old infant is not displaying signs of significant vision impairment.
B) The 6-month-old infant is showing signs of vision impairment but is at an age at which surgery may only be performed if the healthcare provider decides it is necessary.
C) The 3- month-old infant is showing signs of vision impairment but is at an age at which surgery may only be performed if the healthcare provider decides it is necessary.
D) If vision impairment is significant, the infant should undergo surgical removal of the cataract within the first 2 months of life.
Page Ref: 1462
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Differentiate considerations for care of patients with the most common diseases of the eye across the lifespan.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

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4) An older adult client with bilateral cataracts, arthritis, and a hearing deficit is scheduled for cataract surgery. Which is the priority problem for this client?
A) Disturbed body image
B) Fear
C) Inadequate health maintenance skills
D) Anxiety
Answer: C
Explanation: A) The client might have a disturbed body image; however, postoperative care is the highest priority at this time.
B) There is no evidence that the client is fearful.
C) The client has arthritis, which is a chronic condition and may interfere with the client's ability to manage health maintenance.
D) There is no evidence that the client has anxiety.
Page Ref: 1463
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Apply the nursing process in providing culturally competent care to individuals with the most common diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

5) The nurse is planning care for a client scheduled for cataract surgery. Which intervention should the nurse include in the plan of care to help provide a safe environment for the client following surgery?

A) Ensuring fall hazards are removed from the client's home and additional lighting is provided

B) Educating the client about what self-care activities are necessary following surgery

C) Making the client's close family aware of the self-care instructions the client has received

D) Ensuring the client's employer does not expect the client to return to standard duties until clearance for such activities by the healthcare provider

Answer: A

Explanation: A) The removal of fall hazards from the client's home and provision of additional lighting best demonstrates providing a safe environment for the client following surgery.

B) It's important for the client to understand what self-care activities are necessary, but this doesn't relate directly to providing a safe environment.

C) It's important for the client's close family members to be aware of the self-care instructions the client has received, but this doesn't relate directly to providing a safe environment.

D) It's good that the client's employer doesn't expect an immediate return to standard duties, but this doesn't relate directly to providing a safe environment.

Page Ref: 1463

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Apply the nursing process in providing culturally competent care to individuals with the most common diseases of the eye.

MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

6) Which diagnostic technique is used to confirm the location and extent of cataracts?

A) Visually inspecting the optic fundus using an ophthalmoscope

B) Using tonometry to indirectly measure intraocular pressure

C) Revealing a dark area instead of the red reflex through ophthalmoscopy

D) Identifying patient history consistent with risk of cataracts and examining the eye to diagnose the cataract

Answer: D

Explanation: A) Visually inspecting the optic fundus is used to diagnose glaucoma.

B) Using tonometry to measure intraocular pressure is used to diagnose glaucoma.

C) Revealing a dark area is something that would happen only as the cataract matures.

D) Cataracts are diagnosed on the basis of the patient's history and eye examination. The Snellen and Rosenbaum charts are used. A dilated eye exam with either an ophthalmoscope or slit-lamp examination provides a magnified view of the structures of the eye.

Page Ref: 1457

Cognitive Level: Remembering

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with the most common diseases of the eye.

MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

7) A client has been diagnosed with cataracts of both eyes. The client's vision and activities of daily living have become severely impaired. Which collaborative intervention does the nurse anticipate for this client?

A) Corrective lenses for the cataracts

B) Two surgical procedures, separated by a few weeks, to remove the cataracts

C) Two surgical procedures to remove both cataracts at the same time

D) Eyedrops to treat the cataracts

Answer: B

Explanation: A) Cataracts cannot be treated with corrective lenses.

B) Surgery is the only treatment for cataracts. The client will have one cataract removed, and then, in a few weeks, the other cataract will be removed.

C) Surgery is the only treatment for cataracts but both cataracts are not removed on the same day.

D) Cataracts cannot be treated with eyedrops.

Page Ref: 1460

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with the most common diseases of the eye.

MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

8) A client is undergoing surgery to manage glaucoma. When providing postoperative teaching to this client, the nurse should emphasize that the client is now at increased risk for which form of cataracts?

A) Congenital
B) Secondary
C) Radiation
D) Traumatic

Answer: B

Explanation: A) Congenital cataracts are hereditary and appear at birth or in early childhood.
B) A secondary cataract may form following surgery to correct another eye disorder.
C) Radiation cataracts result from long-term exposure to radiation.
D) Traumatic cataracts result from injury to the eye.

Page Ref: 1453

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Describe the etiology of selected diseases of the eye.

MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

9) Which diagram would the nurse use when describing open-angle glaucoma to a client?
A) A diagram showing a completely closed anterior chamber angle
B) A diagram showing a completely occluded outflow of aqueous humor
C) A diagram showing a blockage of the trabecular meshwork and canal of Schlemm
D) A diagram showing congestion of the trabecular meshwork and reduced flow of aqueous humor through the canal of Schlemm
Answer: D
Explanation: A) In open-angle glaucoma, the anterior chamber angle would be normal.
B) In open-angle glaucoma, the anterior chamber angle would be normal, but outflow of aqueous humor would be reduced.
C) The trabecular meshwork and canal of Schlemm are not blocked in open-angle glaucoma.
D) The diagram showing congestion of the trabecular meshwork and reduced flow of aqueous humor through the canal of Schlemm demonstrates open-angle glaucoma.
Page Ref: 1453
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Describe the pathophysiology of the most common diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

10) Which assessment finding is consistent with a diagnosis of open-angle glaucoma?
A) A client loses vision intermittently several times over the course of several hours.
B) A client has an episode of lost vision when experiencing a panic attack.
C) A client loses the ability to see at all during a city-wide blackout.
D) A client experiences gradually diminishing vision in both eyes over an extended period.
Answer: D
Explanation: A) Clients with angle-closure glaucoma may have intermittent episodes lasting several hours before they have a more typical prolonged attack of angle-closure glaucoma.
B) Because of the effect of pupil dilation on aqueous outflow in angle-closure glaucoma, episodes often occur in association with emotional upset.
C) Because of the effect of pupil dilation on aqueous outflow in angle-closure glaucoma, episodes often occur in association with darkness.
D) Open-angle glaucoma tends to be a chronic and gradually progressive disease. It typically affects both eyes, although the pressures and progression may not be symmetric.
Page Ref: 1453
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Describe the etiology of selected diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

11) An older adult client is prescribed a prostaglandin eyedrop to treat glaucoma. When providing client teaching about this medication, which potential side effects should the nurse include? **Select all that apply.**
A) Eye irritation
B) Intermittent loss of eyesight
C) Headaches
D) Clouding of the eyes
E) Systemic effects
Answer: A, E
Explanation: A) The client is taking a prostaglandin analog as eyedrops, which can cause the side effect of eye irritation.
B) A prostaglandin does not cause intermittent loss of eyesight.
C) A prostaglandin does not cause headaches.
D) A prostaglandin does not cause clouding of the eyes.
E) A prostaglandin can cause systemic effects if the eye drops are absorbed through the lacrimal duct.
Page Ref: 1459
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with the most common diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

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12) The nurse is planning care for a client with glaucoma who is experiencing anxiety as a result of the diagnosis. Which intervention should the nurse select to address this need?
A) Assure the client there is nothing to be afraid of.
B) Support the client's use of coping mechanisms.
C) Turn off the lights when leaving the client's room.
D) Refer the client to a counseling psychologist.
Answer: B
Explanation: A) Assuring the client there is nothing to be afraid of minimizes the client's concerns and is not appropriate.
B) Anxiety is a common response to a new diagnosis of glaucoma. Here, the most appropriate intervention would be for the nurse to support the client's use of coping mechanisms.
C) Turning off the lights is not an intervention that will lessen the client's anxiety.
D) Although referral to a psychologist may be necessary at some point, it typically is not an initial course of action.
Page Ref: 1464
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Apply the nursing process in providing culturally competent care to individuals with the most common diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

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13) The nurse is providing teaching to a client who was prescribed an ophthalmic beta blocker for glaucoma. The client is having difficulty understanding how to self-administer the medication. Which instruction by the nurse is best?
A) "Occlude your lacrimal duct."
B) "Close your eyes."
C) "Guard against systemic absorption."
D) "Use punctal occlusion."
Answer: B
Explanation: A) Using terms such as "occlude your lacrimal duct" requires additional explanation to be properly understood by the client.
B) Because systemic absorption may occur with beta blockers, the nurse should teach the client to close the eyes and occlude the lacrimal duct after administration to help reduce systemic absorption. The simplest way to provide this teaching in a way the client will readily understand is by instructing the client to close the eyes.
C) Using terms such as "guard against systemic absorption" requires additional explanation to be properly understood by the client.
D) Using terms such as "use punctal occlusion" requires additional explanation to be properly understood by the client.
Page Ref: 1458
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with the most common diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

14) The nurse is evaluating instructions provided to a client with glaucoma. Which client statement indicates that teaching has been effective?
A) "The eyedrops only need to be used when my eyes hurt."
B) "I can stop the eyedrops when the glaucoma has resolved."
C) "I must use my eyedrops as prescribed for the rest of my life."
D) "I will need to continually increase the dose of my eyedrops."
Answer: C
Explanation: A) Most clients with glaucoma do not experience eye pain.
B) Glaucoma can be controlled but not cured.
C) Glaucoma can be controlled but not cured; the client must use eyedrops for the rest of his life.
D) Increasing the dosage of eyedrops is only necessary if the ocular pressure is not controlled; this must be determined by the healthcare provider, not the client.
Page Ref: 1464
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Apply the nursing process in providing culturally competent care to individuals with the most common diseases of the eye.

MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

15) The nurse is caring for a client who has been using timolol (Timoptic) to manage glaucoma. Which assessment finding supports an adverse effect associated with systemic absorption of the drug?

A) Eye pain
B) Heart rate of 57
C) Urinary frequency
D) Blurred vision

Answer: B

Explanation: A) Eye pain is associated with the use of miotic medications.
B) The onset of bradycardia must be evaluated. Timoptic is a beta-adrenergic blocker. It is associated with bradycardia in some clients.
C) Frequent urination is associated with the use of carbonic anhydrase inhibitors.
D) Blurred vision is associated with the use of miotic medications.

Page Ref: 1419

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with the most common diseases of the eye.

MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

16) The nurse is planning instruction for a client who is newly diagnosed with glaucoma. Which information should be included in this teaching? **Select all that apply.**
A) Manage eye pain with over-the-counter analgesics.
B) Clouding of the affected eye(s) is expected.
C) Self-administer prescribed eye medication properly.
D) Attend follow-up appointments with the physician.
E) Avoid over-the-counter medication unless discussed with the physician.
Answer: C, D, E
Explanation: A) Eye pain of affected eyes is not to be expected and should be reported to the physician.
B) Clouding of the affected eyes is not to be expected and should be reported to the physician.
C) When instructing a client on how to manage the diagnosis of glaucoma, the nurse should include the method to self-administer prescribed eye medication.
D) When instructing a client on how to manage the diagnosis of glaucoma, the nurse should include the importance of attending follow-up appointments with the physician.
E) When instructing a client on how to manage the diagnosis of glaucoma, the nurse should include why the client needs to avoid over-the-counter medication unless discussed with the physician.
Page Ref: 1464
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with the most common diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

17) Which scenario is consistent with secondary congenital glaucoma?
A) A newborn is diagnosed with glaucoma at birth.
B) An infant is diagnosed at 6 months with glaucoma.
C) A 1-year-old infant develops glaucoma following neurofibromatosis.
D) A 5-year-old child is diagnosed with glaucoma.
Answer: C
Explanation: A) The newborn diagnosed at birth with glaucoma has congenital glaucoma.
B) The infant diagnosed at 6 months has infantile glaucoma.
C) Secondary congenital glaucoma results from disorders of the eye or the body, including Sturge-Weber syndrome, Axenfeld-Rieger syndrome, aniridia, and neurofibromatosis, so the 1-year-old infant who develops glaucoma following neurofibromatosis has secondary congenital glaucoma.
D) The child diagnosed at 5 years has juvenile glaucoma.
Page Ref: 1462
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Differentiate considerations for care of patients with the most common diseases of the eye across the lifespan.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

18) The nurse is caring for a client with glaucoma who is prescribed an ophthalmic beta-adrenergic blocking agent. When teaching the client about the therapeutic action of this medication, which statement should the nurse include?
A) "This drug reduces pressure in the eye by relaxing the muscles of the eye."
B) "This medication only needs to be taken when eye pain is experienced."
C) "Systemic absorption may occur, resulting in hypotension, bradycardia, and shortness of breath."
D) "This drug reduces intraocular pressure by decreasing the production of fluid in the eye."
Answer: D
Explanation: A) Relaxation of the ciliary muscle is an effect of prostaglandin analog drugs, another class of medications used in the treatment of glaucoma.
B) This type of drug should be taken once or twice a day, not on an as-needed basis when pain occurs.
C) Systemic absorption is a potential side effect of this type of drug, not the therapeutic action of the drug.
D) Ophthalmic beta-adrenergic blocking agents are one type of pharmacologic therapy used in the treatment of glaucoma. This class of medication works to reduce intraocular pressure by decreasing the production of aqueous humor in the ciliary body.
Page Ref: 1458
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with the most common diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

19) An older adult client tells the nurse that reading is easier when the material is held to the left or right. What should the nurse suspect this client is experiencing?
A) Cataract
B) Detached retina
C) Exudative macular degeneration
D) Nonexudative macular degeneration
Answer: D
Explanation: A) Cloudy vision is seen with cataracts.
B) When the retina detaches, the client experiences floaters, or spots, and lines or flashes of light in the visual field.
C) The macular degeneration is likely nonexudative (dry) because that is the more common kind, and it develops before the exudative (wet) type.
D) Symptoms of age-related macular degeneration usually develop gradually and include needing more light to read, blurriness of print, or a blurred or blind spot in the central vision.
Page Ref: 1454
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Describe the pathophysiology of the most common diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

20) The nurse is providing teaching to a client related to maintaining healthy vision. Which information in the client's history should the nurse identify as a modifiable risk factor for macular degeneration?
A) White ancestry
B) Smoking 1 pack of cigarettes per day
C) 62 years of age
D) Family history of AMD
Answer: B
Explanation: A) Race is a nonmodifiable risk factor.
B) Smoking is a modifiable risk factor.
C) Age is a nonmodifiable risk factor.
D) Family history is a nonmodifiable risk factor.
Page Ref: 1455
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Compare the risk factors for and prevention of selected diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

21) An older adult client with intermediate dry macular degeneration reports vision is suddenly much more distorted and colors do not seem right. Which action by the nurse is priority?

A) Talk with the client to assess for other hallucinations that might be occurring.

B) Check the client's medications for side effects of vision changes.

C) Ensure the client's safety by raising the bedrails.

D) Contact the healthcare provider for an immediate ophthalmologic evaluation.

Answer: D

Explanation: A) The client is not hallucinating, although hallucinations are a sign of exudative macular degeneration as well.

B) The client most likely is not experiencing a side effect of medications.

C) Ensuring the client's safety is important; however, the nurse needs to do more than raising the bedrails.

D) Individuals with dry intermediate macular degeneration can progress to exudative macular degeneration. A sudden distortion in vision and impaired color vision are signs of exudative macular degeneration and require prompt evaluation and treatment. The nurse needs to contact the healthcare provider so that the client can be seen by an ophthalmologist.

Page Ref: 1455

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

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Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Apply the nursing process in providing culturally competent care to individuals with the most common diseases of the eye.

MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

22) Which client most likely will require assistance with properly taking medications for macular degeneration?
A) 72-year-old client, no dementia, no arthritis, hypertension
B) 67-year-old client, dementia, arthritis, no hypertension
C) 47-year-old client, no comorbidities
D) 52-year-old client, gastroesophageal reflux disease (GERD), hypertension
Answer: B
Explanation: A) The client with hypertension will not need assistance with the medications.
B) Two common conditions in older adults that may affect treatment of macular degeneration are tremors and cognitive decline. Hand tremors may make it difficult for the older adult to adequately apply eyedrops, and cognitive decline may cause older adults to forget to take their medications. The client with dementia and arthritis, although not the oldest of these clients, has conditions that are most likely to make taking medications properly difficult.
C) The 47-year-old client will most likely be able to take medications without assistance.
D) The 52-year-old client will most likely be able to take medications without assistance.
Page Ref: 1463
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Differentiate considerations for care of patients with the most common diseases of the eye across the lifespan.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

23) The nurse is preparing discharge instructions for a client with age-related macular degeneration (AMD) and type 1 diabetes mellitus. Which information should the nurse include in this client's teaching plan?

A) Assisted-living facilities

B) Need to have routine eye examinations every 5 years

C) Referral to home care to ensure safety with administering insulin and AMD medications at home

D) Stargardt disease

Answer: C

Explanation: A) The client may or may not need to move to an assisted-living facility.

B) Routine eye examinations for this client should be done every 2 years.

C) The client has macular degeneration and type 1 diabetes, which means the client needs insulin at least once per day. The nurse should refer the client for home care to ensure that the client can safely provide insulin at home as well as assist with other medications the client might need for management of AMD.

D) Stargardt disease is the most common type of juvenile macular degeneration and not likely relevant to this client.

Page Ref: 1464

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Differentiate considerations for care of patients with the most common diseases of the eye across the lifespan.

MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

24) The nurse is caring for a client in the early stage of macular degeneration. Which dietary changes should the nurse recommend to slow the progression of the disease?
A) High-antioxidant diet
B) Low-antioxidant diet
C) Low-fat diet
D) High-fat diet
Answer: A
Explanation: A) A diet high in antioxidants—such as fish; green, leafy vegetables; copper; and zinc—has been shown to slow the progression of macular degeneration in its early to intermediate stage when it is nonexudative.
B) A diet low in antioxidants would not help stop the progression of the condition
C) A low fat diet will not slow the progression of macular degeneration.
D) A high-fat diets will not slow the progression of macular degeneration.
Page Ref: 1455
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with the most common diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

25) A client receiving verteporfin treatment for macular degeneration asks what the expected outcome of treatment is. Which response by the nurse is most appropriate?
A) It will increase the effectiveness of surgery.
B) It will reverse the effects of the disease.
C) It will promote the development of new blood vessels.
D) The progression of the disease will be slowed.
Answer: D
Explanation: A) Surgical therapy is rare as a treatment for AMD and this medication does not improve the efficacy of surgery.
B) The client's condition is not likely to improve.
C) New vessels continuing to grow is a risk of the treatment.
D) One treatment for macular degeneration is the use of verteporfin, a drug that tends to adhere to the surface of new blood vessels The best outcome for this treatment is that it will slow the disease.
Page Ref: 1462
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with the most common diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

26) The home care nurse is assessing a client with macular degeneration. Which interventions would be appropriate to ensure home safety for this client? **Select all that apply.**
A) Keep the stairs free of clutter.
B) Wear socks without shoes when walking in the home.
C) Use one electrical outlet for devices.
D) Have grab bars installed in the bathroom.
E) Remove scatter rugs from the floors in the home.
Answer: A, D, E
Explanation: A) The client with macular degeneration is at risk for injury. To reduce this risk, the nurse should instruct to keep the stairs free of clutter.
B) The client should not walk without proper footwear.
C) Using one electrical outlet in the home could cause an electrical hazard.
D) The client with macular degeneration is at risk for injury. To reduce this risk, the nurse should instruct and plan to help the client have grab bars installed in the bathroom.
E) The client with macular degeneration is at risk for injury. To reduce this risk, the nurse should instruct and plan to help the client remove scatter rugs from the floors in the home.
Page Ref: 1463
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Apply the nursing process in providing culturally competent care to individuals with the most common diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

27) Which eye disease is treated with laser surgery and photodynamic therapy?
A) Congenital cataracts
B) Age-related cataracts
C) Nonexudative macular degeneration
D) Exudative macular degeneration
Answer: D

Explanation: A) Neither laser surgery nor photodynamic therapy is used to treat congenital cataracts.
B) Exudative (wet) macular degeneration may be treated by laser surgery or photodynamic therapy. Macular degeneration of the nonexudative (dry) kind is treated with high-dose antioxidants and zinc. Neither laser surgery nor photodynamic therapy is used to treat age-related cataracts.
C) Macular degeneration of the nonexudative (dry) kind is treated with high-dose antioxidants and zinc.
D) Exudative (wet) macular degeneration may be treated by laser surgery or photodynamic therapy.

Page Ref: 1422, 1456
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with the most common diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

28) Which class of drugs both decreases production of aqueous humor in the eye and increases drainage of aqueous humor from the uveoscleral pathway?
A) Beta-adrenergic blockers
B) Prostaglandin analogs
C) Alpha$_2$-adrenergic agonists
D) Cholinergic agonists
Answer: C
Explanation: A) Beta-adrenergic blockers decrease the production of aqueous humor in the eye, but they do not increase drainage of aqueous humor.
B) Prostaglandin analogs increase drainage of aqueous humor from the uveoscleral pathway, but they do not decrease aqueous humor production.
C) Alpha$_2$-adrenergic agonists both decrease production of aqueous humor in the eye and increase drainage of aqueous humor from the uveoscleral pathway.
D) Cholinergic agonists increase drainage of aqueous humor through the trabecular meshwork via pupillary constriction.
Page Ref: 1458
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with the most common diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

29) Which best describes photophobia?
A) Fear of light
B) Aversion to light
C) Reactive to light
D) Need for light
Answer: B
Explanation: A) It is not necessarily fear; phobia can be fear or aversion.
B) Photophobia is a sensitivity to light those clients with angle-closure glaucoma may sometimes experience, so aversion to light is closest to describing photophobia.
C) There are many different types of reactivity to light, but photophobia is specifically a negative reaction.
D) Photophobia typically involves the avoidance of light, not the need for it.
Page Ref: 1455
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Identify the clinical manifestations of selected diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

30) Which statement about cataract surgery is correct?
A) Cataract surgery should be quick but may have to take place in stages.
B) Cataract surgery may only be done on an inpatient basis with general anesthesia.
C) Cataract surgery is not recommended except in cases of opacification of the remaining posterior capsule.
D) Cataract surgery is typically bilateral and can be performed in a single day.
Answer: A
Explanation: A) Cataract surgery should be quick because it typically is done on an outpatient basis with only local anesthesia. If the patient presents with bilateral cataracts, however, surgery is typically performed on only one eye at a time, with an interval of days to several weeks before surgery is performed on the second eye.
B) Cataract surgery is not typically done on an inpatient basis and does not usually involve general anesthesia.
C) Opacification of the remaining posterior capsule is a secondary cataract, which may form following cataract surgery and also should be removed.
D) If a client has bilateral cataracts, the surgery to remove them would typically be performed on different days.
Page Ref: 1460
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 18.B. Analyze diseases of the eye as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with the most common diseases of the eye.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with a disease of the eye.

Exemplar 18.C Eye Injuries

1) The nurse is caring for a client who recently sustained a blow to the head. Which assessment finding suggests that the client should be more closely evaluated for retinal detachment?
A) Eye pain and redness
B) Floaters in the visual field
C) Subconjunctival hemorrhage
D) Hyphema
Answer: B
Explanation: A) Eye pain and redness are not associated with retinal detachment.
B) Of the choices listed, only floaters in the visual field are suggestive of retinal detachment.
C) Although subconjunctival hemorrhage may occur following a blow to the head, it is unrelated to detachment of the retina.
D) Although hyphema may occur following a blow to the head, it is unrelated to detachment of the retina.
Page Ref: 1468
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.C. Analyze eye injuries as they relate to sensory perception. Identify the clinical manifestations of eye injuries.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with an eye injury.

2) A client with an eye injury describes spots in the field of vision. Which potential outcome should cause the nurse the most concern?
A) Immediately lose all vision
B) Progressive deterioration of vision
C) Experience intense eye pain
D) Conjunctiva will become red and edematous
Answer: B
Explanation: A) Complete vision loss would be more likely with penetrating or perforating trauma or burn injuries.
B) "Floaters," or irregular lines or spots in the client's field of vision, are a symptom of retinal detachment. With retinal detachment, the client is at risk for progressive deterioration of vision.
C) Intense eye pain is more likely with corneal abrasions or a foreign body being on the conjunctiva.
D) A red, edematous conjunctiva is more likely with burns.
Page Ref: 1468
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.C. Analyze eye injuries as they relate to sensory perception. Identify the clinical manifestations of eye injuries.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with an eye injury.

3) A client comes into the emergency department with an eye injury. Which assessment findings suggest that this injury is the result of blunt trauma? **Select all that apply.**
A) Lid ecchymosis
B) Eye pain and decreased sharpness of vision
C) Photophobia and eye tearing
D) A well-defined bright area of erythema under the conjunctiva
E) A feeling of something in the eye
Answer: A, B, D
Explanation: A) Blunt trauma to the eye can cause lid ecchymosis, or a black eye.
B) Eye pain can occur because of trauma-related hyphema, or bleeding into the anterior chamber of the eye.
C) Photophobia and eye tearing are most often seen in corneal abrasions, not blunt trauma.
D) Blunt trauma to the eye can cause a subconjunctival hemorrhage, which would be indicated by a well-defined bright area of erythema under the conjunctiva.
E) A feeling of something in the eye is typically caused by a foreign body on the conjunctiva.
Page Ref: 1469
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.C. Analyze eye injuries as they relate to sensory perception. Identify the clinical manifestations of eye injuries.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with an eye injury.

4) Which client is most at risk for eye injuries?
A) A firefighter who wears all required safety gear on calls
B) A baseball player who wears nothing over the eyes
C) A self-employed home worker who wears ANSI Z87 eyewear when doing any household cleaning or yard work
D) A construction worker who wears OSHA-required eyewear at all times while on site
Answer: B
Explanation: A) Although the firefighter is in a more dangerous lines of work, safety gear is being worn.
B) Protective eyewear is estimated to prevent more than 90% of all injuries, but more than 78% of individuals with eye injuries reported not wearing eyewear at the time of injury. Based on this data, the baseball player is most at risk for eye injuries because of the lack of eye protection and the potential for getting hit in the face with a ball.
C) The home worker is likely to be at least risk for eye injuries and yet still uses appropriate eyewear when cleaning or doing yard work.
D) Although the construction worker is in a more dangerous line of work, protective gear is being worn.
Page Ref: 1467
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.C. Analyze eye injuries as they relate to sensory perception. Compare the risk factors for and prevention of eye injuries.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with an eye injury.

5) The nurse is planning a teaching seminar for parents of school-age children that focuses on eye safety. Which information should the nurse include in this educational session?

A) All children should wear goggles when playing outdoors at all times.

B) Sunglasses need only be worn during the summer months.

C) Supervise young children when lighting fireworks.

D) Keep sharp objects out of the reach of young children.

Answer: D

Explanation: A) Eye protection should be worn when participating in sports that lead to eye injury, such as baseball or tennis; it is not necessary at all times.

B) Sunglasses should be worn whenever a child is exposed to bright light outdoors, regardless of the season.

C) Parents should not permit preschool-age children to handle or light fireworks, even with supervision.

D) Scissors, knives, and other sharp objects should be kept out of the reach of young children.

Page Ref: 1471

Cognitive Level: Applying

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 18.C. Analyze eye injuries as they relate to sensory perception. Differentiate considerations for care of patients with eye injuries across the lifespan.

MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with an eye injury.

6) A client is diagnosed with a detached retina. Which is the priority problem for this client?
A) Risk for infection
B) Anxiety
C) Acute pain
D) Reduced vision
Answer: D
Explanation: A) Risk for infection would not be a priority until the retina is reattached.
B) The client will most likely demonstrate anxiety with the loss of vision; however, preventing permanent retinal injury is the priority.
C) A detached retina is not typically accompanied by pain.
D) Immediate intervention is required for a client with a detached retina to restore vision.
Page Ref: 1472
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 18.C. Analyze eye injuries as they relate to sensory perception. Apply the nursing process in providing culturally competent care to individuals with eye injuries.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with an eye injury.

7) A client presents in the emergency room with a penetrating eye injury. The object is still present in the eye. Which nursing action is priority?
A) Apply anesthetic drops.
B) Apply eye ointment.
C) Remove the object.
D) Stabilize the object.
Answer: D
Explanation: A) Anesthetic drops would be appropriate prior to the removal of a foreign body from the eye.
B) Use of eye ointment would be applicable after the removal of a foreign body or for a corneal abrasion.
C) Removal of a foreign body from the eye is appropriate, but not removal of a penetrating object, which could cause additional tissue damage.
D) For a severe or penetrating injury, promote rest and stabilize the injured eye by applying an eye pad or gauze dressing loosely over both the affected and unaffected eye. Stabilize any penetrating object, if possible. These measures reduce eye movement and can help preserve the client's vision.
Page Ref: 1472
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.C. Analyze eye injuries as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of individuals with eye injuries.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with an eye injury.

8) A client recovering from a penetrating eye injury tells the nurse that some shadows and movement can be seen with the eye. Based on this data, which action should the nurse take?
A) Note a deterioration in vision.
B) Administer ultrasonography to assess the eye for a detached retina.
C) Compare this data to the initial assessment.
D) Note an improvement in vision.
Answer: C
Explanation: A) Deterioration in vision would be indicated by a lack of sight, but there is no way to know whether the client's condition has improved or worsened without comparing it to the baseline.
B) The client's ability to see shadows and movement does not indicate the need for ultrasonography, but basic diagnostic testing of the eye's acuity and pupil reactivity and size is warranted.
C) An initial assessment provides valuable information about the effect of the injury on the patient's vision and a baseline for future comparisons.
D) In this case, if the client had been unable to see through the injured eye and now is able to see shadows and movement, that would indicate an improvement in vision.
Page Ref: 1471
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 18.C. Analyze eye injuries as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of individuals with eye injuries.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with an eye injury.

9) The nurse is caring for a client with a corneal abrasion. Which collaborative intervention should the nurse anticipate being included in the client's care?
A) Bedrest and an eye shield
B) Surgery
C) Applying antibiotic ointment and an eye shield
D) Flushing the eye with normal saline
Answer: C
Explanation: A) Bedrest with an eye shield would be indicated for the care of the client with a blunt trauma to the eye.
B) Surgery is indicated for penetrating injuries to the eye but is usually not necessary for corneal abrasion.
C) Applying antibiotic ointment and an eye shield would be indicated in the care of the client with a corneal abrasion. An eye shield such as an eye patch is further indicated because of the client's likelihood of rubbing the eye.
D) Flushing the eye with normal saline is indicated for a burn injury to the eye.
Page Ref: 1467
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 18.C. Analyze eye injuries as they relate to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of individuals with eye injuries.

MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with an eye injury.

10) The nurse is providing teaching to an older adult client related to avoiding eye injury. Which action should the nurse identify as an intervention to address the number-one cause of eye injuries in older adults?
A) Turning down the temperature of the client's home water heater
B) Storing all harsh chemicals out of easy reach
C) Ensuring the client wears protective goggles when engaging in outdoor activities
D) Addressing slippery floors and other fall hazards in the client's home
Answer: D
Explanation: A) Ensuring an appropriate water heater temperature would prevent scalds but does not specifically address risk of eye injury.
B) Storing chemicals out of reach is probably not necessary unless there are children in the home; furthermore, keeping chemicals in a place that requires use of a stepstool or ladder may actually increase an older adult's risk of falls.
C) Wearing eye protection is a good idea when participating in certain sports, but it is not necessary at all times and does not reduce the risk of fall-related injuries.
D) The number-one cause of eye injury in older adults is falling. Primary causes of falls in older adults include slipping on wet surfaces and falling down stairs, so addressing fall hazards such as slippery floors would best prevent eye injuries for this client.
Page Ref: 1471
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.C. Analyze eye injuries as they relate to sensory perception. Differentiate considerations for care of patients with eye injuries across the lifespan.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with an eye injury.

11) Which statement is true about eye injuries?
A) Eye injuries almost always take place in the home.
B) Construction workers have a reduced risk of eye injury because of the many protective measures they take.
C) The pathophysiology of an eye injury depends on the nature of the injury.
D) Eye injuries are relatively uncommon with advances in safety and risk prevention.
Answer: C
Explanation: A) Eye injuries may take place in the home, but they may also occur in other settings such as recreational sports events and the workplace.
B) Adults who are at greatest risk of eye injuries include contractors, woodworkers, welders, and electricians, all of which occupations are heavily involved in construction work.
C) The pathophysiology of an eye injury depends on the nature of the injury.
D) Eye injuries affect more than 2.5 million Americans every year. Each year 50,000 people will permanently lose all or part of their vision as a result of injury.
Page Ref: 1468
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.C. Analyze eye injuries as they relate to sensory perception. Describe the pathophysiology of eye injuries.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with an eye injury.

12) Which information should the nurse provide to a client with a corneal abrasion?
A) Such injuries are typically painless.
B) The superficial epithelium is completely removed.
C) The integrity of the superficial epithelium is disturbed.
D) The surface of the cornea sustains penetrating trauma.
Answer: C
Explanation: A) Superficial corneal abrasions typically heal quickly but are extremely painful.
B) Completely removing the superficial epithelium would destroy the eye.
C) A disruption is a disturbance, in this case to the integrity of the superficial epithelium.
D) An abrasion is not a penetrating injury. Objects that commonly cause corneal abrasion include contact lenses, eyelashes, small foreign bodies such as dust and dirt, and fingernails. Drying of the eye surface and chemical irritants also may result in a corneal abrasion.
Page Ref: 1467
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.C. Analyze eye injuries as they relate to sensory perception. Describe the pathophysiology of eye injuries.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with an eye injury.

Exemplar 18.D Peripheral Neuropathy

1) A client with a long history of type 2 diabetes mellitus complains of occasional coldness and numbness in both hands and both feet. These complaints are suggestive of which condition?
A) Idiopathic peripheral neuropathy
B) Mononeuropathy
C) Polyneuropathy
D) Hereditary peripheral neuropathy
Answer: C
Explanation: A) An idiopathic peripheral neuropathy would have no known cause, but for this client diabetes would be a likely cause of neuropathy.
B) Mononeuropathies are isolated and affect only single nerves; they are commonly associated with injury or trauma.
C) Polyneuropathies, the most common types of neuropathy associated with diabetes, are bilateral sensory disorders. The manifestations appear first in the toes and feet and progress upward. The fingers and hands also may be involved, but usually only in later stages of diabetes.
D) Diabetes is not hereditary, so there is no reason to suspect hereditary peripheral neuropathy.
Page Ref: 1475
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 18.D. Analyze peripheral neuropathy as it relates to sensory perception. Describe the pathophysiology of peripheral neuropathy.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with peripheral neuropathy.

2) The nurse is providing teaching to a client at risk for acquired peripheral neuropathy. Which activity should the nurse suggest the client modify or avoid to reduce the risk of this condition?
A) Working as an automobile mechanic on weekends
B) Playing tennis every Saturday
C) Drinking one six-pack of beer per day
D) Typing on the computer for several hours each day
Answer: C
Explanation: A) Working as an automobile mechanic would not cause peripheral neuropathy.
B) Playing tennis would not cause peripheral neuropathy.
C) The client has a daily alcohol intake of one six-pack of beer. Alcohol abuse is a risk factor for the development of acquired peripheral neuropathy, so the client should be discouraged from drinking.
D) Typing on the computer for several hours each day might cause some localized nerve compression in the wrists but would not contribute to peripheral neuropathy.
Page Ref: 1475
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.D. Analyze peripheral neuropathy as it relates to sensory perception. Compare the risk factors for and prevention of peripheral neuropathy.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with peripheral neuropathy.

3) The nurse is providing client teaching on Guillain-Barré syndrome. Which explanation for a client's false perception that socks are being worn is accurate?
A) Confusion is a part of this disorder, so the client is simply confused as to whether socks are being worn.
B) This disorder causes a change in sensation that makes the client feel as if socks are being worn.
C) The medications used to treat this disorder cause the client to feel as if socks are being worn.
D) Tactile hallucinations are part of this disorder, so the client is hallucinating that socks are present.
Answer: B
Explanation: A) Confusion is not a part of the disorder.
B) Changes in sensation related to Guillain-Barré syndrome frequently cause a "stocking-glove" pattern–in which clients feel as if stockings and gloves are being worn when they are not–as well as pain in the hands, feet, and legs.
C) Medications are not causing the client to feel as if socks are being worn.
D) Tactile hallucinations are not part of the disorder.
Page Ref: 1437, 1474
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.D. Analyze peripheral neuropathy as it relates to sensory perception. Identify the clinical manifestations of peripheral neuropathy.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with peripheral neuropathy.

4) A client with peripheral neuropathy complains of leg aches and the inability to be comfortable. Which problem would be a priority for the client at this time?
A) Anxiety
B) Ineffective peripheral tissue perfusion
C) Risk for falling
D) Chronic pain
Answer: D
Explanation: A) The client may have anxiety but chronic pain is the main problem.
B) Ineffective peripheral tissue perfusion is the likely reason for the client's pain and discomfort, but the nurse's primary interventions for this client will relate to pain management, safety, and comfort, not to directly treating the cause of the pain.
C) There is no evidence that the client is at risk for falling.
D) The client reports aching legs and an inability to be comfortable. The problem most appropriate for the client at this time would be chronic pain.
Page Ref: 1478
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 18.D. Analyze peripheral neuropathy as it relates to sensory perception. Apply the nursing process in providing culturally competent care to an individual with peripheral neuropathy.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with peripheral neuropathy.

5) The nurse is planning care for an adolescent client recently diagnosed with Charcot-Marie-Tooth syndrome. Which intervention is the highest priority?
A) Managing the client's chronic pain
B) Reducing the client's risk for injury
C) Addressing the client's perfusion problems
D) Relaxing the client to reduce stress
Answer: B
Explanation: A) As the client ages, chronic pain will likely become a concern, but it is not likely at this stage in the disease.
B) In the early stage of Charcot-Marie-Tooth syndrome, the disease may manifest in clumsiness due to foot drop and muscle weakness in the feet, ankles, and legs, so addressing risk for injury is the priority for this client.
C) Addressing problems with perfusion would not be the priority.
D) Even if the client feels stress-induced anxiety because of the illness, that is not a priority over ensuring the safety of the client.
Page Ref: 1477
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 18.D. Analyze peripheral neuropathy as it relates to sensory perception. Differentiate considerations for care of patients with peripheral neuropathy across the lifespan.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with peripheral neuropathy.

6) A client who receives vitamin B_{12} injections to control peripheral neuropathy is concerned about the development of increased tingling in the fingers and toes. Which response should the nurse make to the client?
A) "The tingling suggests that you are due for another injection."
B) "The tingling means that the injections are not producing their intended effect."
C) "The tingling is a common side effect of B_{12} injections."
D) "The tingling is most likely unrelated to your injections."
Answer: A
Explanation: A) Vitamin B_{12} injections are given to reduce tingling related to peripheral neuropathy.
B) A recent increase in tingling suggests that the medication has been working but the client is due for another injection soon.
C) Tingling is not a side effect of vitamin B_{12} injections.
D) Since the client is receiving vitamin B_{12} injections for neuropathy, the tingling is most likely related to the medication.
Page Ref: 1475
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 18.D. Analyze peripheral neuropathy as it relates to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with peripheral neuropathy.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with peripheral neuropathy.

7) Which client's clinical manifestations are most consistent with Guillain-Barré syndrome?
A) A 13-year-old client feels weakness in the feet, ankles, and legs.
B) A 5-year-old client feels leg pain and wants to be carried.
C) A 55-year-old client experiences a lack of hand strength.
D) A 23-year-old client with peripheral neuropathy has poor glycemic control.
Answer: B
Explanation: A) The 13-year-old client's feeling of weakness in the feet, ankles, and legs is likely an early manifestation of Charcot-Marie-Tooth syndrome.
B) Children younger than 6 years old with Guillain-Barré syndrome may present with a refusal to walk and pain in the legs.
C) The 55-year-old client's lack of hand strength is likely due to more advanced CMT syndrome.
D) The 23-year-old client with poor glycemic control is likely due to diabetes, which is probably the cause of the client's peripheral neuropathy.
Page Ref: 1477
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.D. Analyze peripheral neuropathy as it relates to sensory perception. Differentiate considerations for care of patients with peripheral neuropathy across the lifespan.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with peripheral neuropathy.

8) The nurse is planning teaching for a client diagnosed with diabetic neuropathy. Which information should the nurse include in this teaching?
A) Set the water heater at 120°F.
B) Avoid hand and foot massages.
C) Use a mirror to inspect feet daily.
D) Increase medication for pain as necessary.
Answer: C
Explanation: A) Setting the water heater at 120°F is incorrect because it is too hot and the client may be scalded because of lack of sensation.
B) Avoiding hand and foot massages is incorrect because this therapy will relax the client, increase the circulation, reduce the need for medication, and increase the psychologic benefits of touch, including the ability to be soothed, comforted, held, and loved.
C) Using a mirror to inspect the feet daily is recommended because the client may not feel the formation of pressure points, blisters, or ulcers.
D) Increasing medication for pain as necessary is incorrect because it can further decrease touch sensation by clouding the sensorium and inducing lethargy, which requires additional supervision and monitoring to ensure safety.
Page Ref: 1478
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.D. Analyze peripheral neuropathy as it relates to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with peripheral neuropathy.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with peripheral neuropathy.

9) Which statement regarding idiopathic neuropathy is true?

A) Idiopathic neuropathy is hereditary in nature.

B) Idiopathic neuropathy has no known cause.

C) Idiopathic neuropathy is caused by nutritional deficits.

D) Idiopathic neuropathy is caused by disease or illness.

Answer: B

Explanation: A) Idiopathic neuropathies are not hereditary.

B) Idiopathic neuropathies are from an unknown cause and account for up to 30% of neuropathies.

C) Idiopathic neuropathies are not caused by a nutritional deficit.

D) Idiopathic neuropathies are not caused by any identifiable illness.

Page Ref: 1474

Cognitive Level: Remembering

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 18.D. Analyze peripheral neuropathy as it relates to sensory perception. Describe the etiology of peripheral neuropathy.

MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with peripheral neuropathy.

10) Which degree of alcohol use has been implicated in the development of alcohol-related neuropathy?

A) Long term and excessive

B) Short term and light

C) Intermittent and severe

D) Acute and toxic

Answer: A

Explanation: A) Alcoholic neuropathy is damage to the nerves that results from long-term, excessive use of alcohol.

B) This type of alcohol use is not short term and light.

C) This type of alcohol use is not intermittent.

D) This type of alcohol use is not acute and toxic.

Page Ref: 1475

Cognitive Level: Remembering

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 18.D. Analyze peripheral neuropathy as it relates to sensory perception. Describe the etiology of peripheral neuropathy.

MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with peripheral neuropathy.

11) Which statement regarding risk factors for peripheral neuropathy is accurate?
A) Extremely short people are at the highest level of risk for developing peripheral neuropathy.
B) Height is a risk factor for women but not a proven risk factor for men.
C) Height is a risk factor for men but not a proven risk factor for women.
D) Risk for peripheral neuropathy is proportional to height for both men and woman.
Answer: D
Explanation: A) Extremely short people are not at the highest risk for developing peripheral neuropathy.
B) Height has been identified as a risk factor for the development of peripheral neuropathy, independent of gender or presence of diabetes mellitus.
C) Height has been identified as a risk factor for the development of peripheral neuropathy, independent of gender or presence of diabetes mellitus.
D) Men who are taller than 171.5 cm (5 ft 6 in.) and women who are taller than 164.5 cm (5 ft 4 in.) are at higher risk for developing peripheral neuropathy.
Page Ref: 1475
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.D. Analyze peripheral neuropathy as it relates to sensory perception. Compare the risk factors for and prevention of peripheral neuropathy.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with peripheral neuropathy.

Exemplar 18.E Meniere Disease

1) A client with Meniere disease asks why the condition developed. Which information should the nurse include when discussing the etiology of the condition? **Select all that apply.**
A) Allergies might cause it to develop.
B) A viral infection can cause the condition.
C) It can be considered an autoimmune reaction.
D) It can be caused by a constriction of blood vessels.
E) Blocking of the ear canals is the most common cause.
Answer: A, B, C, D
Explanation: A) The etiology of Meniere disease is unknown; however, allergies are theorized to be a cause.
B) The etiology of Meniere disease is unknown; however, viruses are theorized to be a cause.
C) The etiology of Meniere disease is unknown; however, an autoimmune reaction is theorized to be a cause.
D) The etiology of Meniere disease is unknown; however, constriction of blood vessels is theorized to be a cause.
E) There is no evidence that blockage of the ear canals is the most common cause for Meniere disease.
Page Ref: 1479
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 18.E. Analyze Meniere disease as it relates to sensory perception. Describe the etiology of Meniere disease.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with Meniere disease.

2) The nurse is preparing a tool to teach clients on the pathophysiology of Meniere disease. Which ear structure should the nurse identify that is affected by excessive endolymph fluid?
A) Inner ear
B) External ear canal
C) Semicircular canals
D) Tympanic membrane
Answer: A
Explanation: A) The symptoms of Ménière disease are caused by an abnormal buildup of endolymph fluid in the inner ear, which causes the membranous labyrinth to dilate.
B) Excessive endolymph fluid does not affect the external ear canal.
C) Excessive endolymph fluid does not affect the semicircular canals.
D) Excessive endolymph fluid does not affect the tympanic membrane.
Page Ref: 1479-1480
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 18.E. Analyze Meniere disease as it relates to sensory perception. Describe the pathophysiology of Meniere disease.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with Meniere disease.

3) The nurse reviews data collected from a client with Meniere disease. Which information in the health history should the nurse identify as nonmodifiable risk factors for the disorder? **Select all that apply.**

A) Age
B) Smoking
C) Activity level
D) Family history
E) Alcohol intake

Answer: A, D

Explanation: A) Age is a nonmodifiable risk factor for Meniere disease.
B) Smoking is a modifiable risk factor for a person diagnosed with Meniere disease.
C) Activity level is neither a modifiable nor nonmodifiable risk factor for Meniere disease.
D) Family history is a nonmodifiable risk factor for Meniere disease.
E) Alcohol intake is a modifiable risk factor for a person diagnosed with Meniere disease.

Page Ref: 1480

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 18.E. Analyze Meniere disease as it relates to sensory perception. Compare the risk factors for and prevention of Meniere disease.

MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with Meniere disease.

4) A client who experiences repeated episodes of Meniere disease asks what can be done to prevent future episodes. Which response should the nurse make to the client?
A) "Avoiding high-sodium foods is a recommendation."
B) "There are no specific actions to take to reduce the symptoms."
C) "Stopping smoking will help reduce the symptoms of the condition."
D) "There is a surgical procedure that can be done that cuts the nerves to the ear area."
Answer: C
Explanation: A) High sodium foods are not identified to reduce the symptoms of Meniere disease.
B) Actions such as smoking cessation and abstinence of alcohol may reduce the symptoms of the condition.
C) If Meniere disease is diagnosed, smoking may trigger or worsen symptoms and it would be beneficial for the client to modify this behavior.
D) There are surgical procedures for Meniere disease; however, these are not considered unless all other interventions are unsuccessful in treating the condition.
Page Ref: 1480
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.E. Analyze Meniere disease as it relates to sensory perception. Compare the risk factors for and prevention of Meniere disease.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with Meniere disease.

5) The nurse is caring for a client diagnosed with an acute episode of Meniere disease. Which findings should the nurse expect to assess in this client? **Select all that apply.**
A) Nausea
B) Vomiting
C) Ear drainage
D) Severe vertigo
E) Difficulty with balance
Answer: A, B, D, E
Explanation: A) Nausea is a symptom of an acute episode of Meniere disease.
B) Vomiting is a symptom of an acute episode of Meniere disease.
C) Ear drainage is not a symptom of Meniere disease.
D) Severe vertigo is a symptom of an acute episode of Meniere disease.
E) Difficulty with balance is a symptom of an acute episode of Meniere disease.
Page Ref: 1480
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.E. Analyze Meniere disease as it relates to sensory perception. Identify the clinical manifestations of Meniere disease.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with Meniere disease.

6) A client with a new onset of symptoms is being evaluated for Meniere disease. Which findings indicate to the nurse that the client is experiencing definitive symptoms of the condition? **Select all that apply.**
A) Tinnitus
B) Nausea and vomiting
C) Intermittent hearing loss
D) Loss of middle hearing with vertigo
E) Three episodes of vertigo lasting 6 hours
Answer: A, C, D, E
Explanation: A) To receive a definitive diagnosis of Meniere disease, the client must experience tinnitus.
B) Nausea and vomiting is not a symptom to receive a definitive diagnosis of Meniere disease.
C) To receive a definitive diagnosis of Meniere disease, the client must experience intermittent hearing loss.
D) Varying hearing loss in the low and mid frequencies in the affected ear occurring at least once in relationship with vertigo is a symptom to definitively diagnose Meniere disease.
E) To receive a definitive diagnosis, an individual must have two or more episodes of vertigo, lasting from 20 minutes to 12 hours.
Page Ref: 1480
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.E. Analyze Meniere disease as it relates to sensory perception. Identify the clinical manifestations of Meniere disease.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with Meniere disease.

7) A client is being evaluated for symptoms of Meniere disease. Which diagnostic test should the nurse anticipate being prescribed to assess the client's hearing loss?

A) Audiometry
B) Videonystagmography
C) Video head impulse test
D) Magnetic resonance imaging

Answer: A

Explanation: A) Audiometry is used to diagnose a hearing loss.
B) Videonystagmography is used to evaluate balance by assessing eye movement.
C) Video head impulse test measures eye reactions to abrupt movement.
D) An MRI is used to rule out other causes of a hearing loss.

Page Ref: 1481
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 18.E. Analyze Meniere disease as it relates to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with Meniere disease.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with Meniere disease.

8) The nurse is caring for a client with tinnitus caused by Meniere disease. Which therapies should the nurse expect to be prescribed for this client? **Select all that apply.**
A) Diuretics
B) Alprazolam
C) Masking devices
D) White noise machine
E) Middle ear injections
Answer: B, C, D
Explanation: A) Diuretics are used to treat vertigo.
B) Alprazolam is a medication used to treat tinnitus.
C) Masking devices are used to treat tinnitus.
D) A white noise machine is used to treat tinnitus.
E) Middle ear injections are used to treat vertigo.
Page Ref: 1481
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 18.E. Analyze Meniere disease as it relates to sensory perception. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with Meniere disease.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with Meniere disease.

9) An adolescent experiences vertigo and dizziness several times a year. On which areas should the focus be when assessing the client for Meniere disease? **Select all that apply.**
A) Neck pain
B) Shoulder pain
C) Amount of sleep
D) Amount of physical activity
E) History of migraine headaches
Answer: A, B, C, E
Explanation: A) The major risk factors for vertigo and dizziness in adolescents includes muscle pain in the neck.
B) The major risk factors for vertigo and dizziness in adolescents includes muscle pain in the shoulder area.
C) The amount of sleep is identified as a major risk factor for vertigo and dizziness in adolescents.
D) The amount of physical activity is not identified as a major risk factor for vertigo and dizziness in adolescents.
E) A history of migraine headaches is identified as a major risk factor for vertigo and dizziness in adolescents.
Page Ref: 1482
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 18.E. Analyze Meniere disease as it relates to sensory perception. Differentiate considerations for care of patients with Meniere disease across the lifespan.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with Meniere disease.

10) During an assessment, an older client reports experiencing periodic dizziness and vertigo. For which reasons should the nurse suspect that treatment for Meniere disease has yet to be prescribed? **Select all that apply.**

A) Symptoms mimic other disease processes
B) Meniere disease does not affect older adults
C) Typical symptoms of Meniere disease absent
D) Medication side effects could be causing the symptoms
E) Medications to treat Meniere disease ineffective in this population

Answer: A, C, D

Explanation: A) Finding the cause of dizziness and vertigo in older adults can be complicated due to the number of other chronic illnesses that occur in this age group.
B) Meniere disease does affect older adults.
C) The diagnosis of Meniere disease can be difficult in the elderly because they may not follow the typical disease trajectory.
D) Medications that an older client may be prescribed could be causing the symptoms of dizziness and vertigo.
E) There is no evidence that medications used to treat Meniere disease are ineffective in older adults.

Page Ref: 1482
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 18.E. Analyze Meniere disease as it relates to sensory perception. Differentiate considerations for care of patients with Meniere disease across the lifespan.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with Meniere disease.

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11) The nurse visits the home of an older client with Meniere disease. Which action should the nurse take when the client experiences an acute attack during the visit?
A) Provide the client with a cool beverage
B) Ambulate with the client around the room
C) Instruct to sit quiet and still until the dizziness and vertigo subsides
D) Assist the client to bend forward to place the head between the knees
Answer: C
Explanation: A) A cool beverage is not an action to help a client having an acute attack of Meniere disease.
B) The client should not ambulate when an acute attack of Meniere disease occurs as this could cause a fall or other injury.
C) The client should be instructed to assume a comfortable position when an attack of Meniere disease occurs and to remain still and quiet until the attack subsides.
D) There is no reason to have the client bend forward and place the head between the knees during an acute attack of Meniere disease.
Page Ref: 1483
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 18.E. Analyze Meniere disease as it relates to sensory perception. Apply the nursing process in providing culturally competent care to an individual with Meniere disease.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with Meniere disease.

12) The nurse instructs a client with Meniere disease on actions to take for self-management of the symptoms. Which client statement indicates that teaching has been effective?
A) "I stopped drinking beer in the evening."
B) "I walk slower when the vertigo occurs."
C) "I only drink coffee with lunch and dinner."
D) "I only smoke after a meal and before bedtime."
Answer: A
Explanation: A) The client with Meniere disease should avoid alcohol as this is a modifiable risk factor for the symptoms. Eliminating alcohol indicates that teaching has been effective.
B) The client should be instructed to sit in a comfortable position and remain still and quiet until an attack of Meniere disease subsides.
C) The client should be instructed to avoid caffeine as this is a modifiable risk factor for the symptoms of Meniere disease.
D) The client should be instructed to avoid smoking as this is a modifiable risk factor for the symptoms of Meniere disease.
Page Ref: 1483
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 18.E. Analyze Meniere disease as it relates to sensory perception. Apply the nursing process in providing culturally competent care to an individual with Meniere disease.
MNL LO: Demonstrate understanding of the concept of sensory perception in the care of a patient with Meniere disease.

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Module 19 Sexuality

The Concept of Sexuality

1) A client experiencing menopause is concerned that intercourse with a partner has become increasingly painful. Which reason should the nurse explain about the changes in this client's body after menopause?
A) Cervical mucus is thicker.
B) Estrogen levels increase.
C) Sexual desire diminishes.
D) Vaginal lubrication decreases.
Answer: D
Explanation: A) The client's concerns are not related to cervical mucus.
B) Estrogen levels decrease in menopause.
C) Older women may experience an increase in sexual desire after menopause.
D) Vaginal lubrication and elasticity decrease with menopause which can lead to painful intercourse.
Page Ref: 1491
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 19.1. Outline the development of sexuality.
MNL LO: Analyze the concept of sexuality and its application to nursing care.

2) A female client reports having difficulty with sexual relations because of a recent weight gain. On which area should the nurse focus when planning this client's care?
A) Sexual self-concept
B) Gender identity
C) Body image
D) Gender-role behavior
Answer: C
Explanation: A) Sexual self-concept determines the gender and kinds of individuals to whom the person is attracted; the individual's values about when, where, how, and with whom they express their sexuality; and the individual's ability to freely choose sexual partners.
B) Gender identity refers to an individual's self-image as a male, female, or transgender person.
C) An individual's body image is constantly changing. How people feel about their bodies is related to sexuality, and people who have a poor body image may respond negatively to sexual arousal. This is what the client is experiencing.
D) Gender-role behavior is the outward expression of an individual's sense of maleness or femaleness, as well as the expression of what is perceived as gender-appropriate behavior.
Page Ref: 1491
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 19.2. Define and analyze the components of sexual health.
MNL LO: Analyze the concept of sexuality and its application to nursing care.

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3) Which statement is *true* with regard to human sexuality?
A) The term "intersex" is used to describe individuals whose gender identity and/or gender expression differs from the gender they were assigned at birth.
B) Members of the medical and psychological professions believe that all transgender individuals are affected by gender dysphoria.
C) Today, the terms "transgender" and "transsexual" are typically used interchangeably.
D) Transgender individuals are at increased risk for violence, discrimination, poverty, and limited access to healthcare.
Answer: D
Explanation: A) Intersex individuals are people who have contradictions among their chromosomal gender, gonadal gender, internal sex organs, and external genital appearance, whereas transgender individuals are people whose gender identity and/or expression differs from the gender they were assigned at birth.
B) Some—but not all—transgender individuals are affected by a condition called gender dysphoria, which involves strong and persistent feelings of discomfort with one's assigned gender.
C) In the past, transgender individuals were often referred to as transsexual, although use of this term is now usually limited to people who have changed or seek to change their sexual anatomy through medical interventions.
D) Transgender individuals are at increased risk for violence, discrimination, poverty, and limited access to healthcare.
Page Ref: 1495
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 19.2. Define and analyze the components of sexual health.
MNL LO: Analyze the concept of sexuality and its application to nursing care.

4) During a health history, the nurse learns that a male client has a recent onset of erectile dysfunction (ED). Which assessment question is likely to elicit the most useful information about factors that may be contributing to the client's ED?
A) "Does this occur often?"
B) "For what diseases and disorders have you been treated?"
C) "Are you on any medications?"
D) "How does your partner feel about this problem?"
Answer: B
Explanation: A) Asking the client whether ED occurs often will not help identify the cause of the problem.
B) The client's health history can provide clues regarding the underlying cause of the erectile dysfunction (ED). The question "For what diseases and disorders have you been treated?" would most likely provide useful information as to possible causes for the recent onset of the disorder.
C) Inquiring about the client's medication use would be useful; however, the inquiry should be phrased as an open-ended question and not a closed-ended question, as it is here.
D) Asking the client how partners feels about the situation will not help identify the cause of the problem.
Page Ref: 1498
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 19.6. Differentiate among common assessment procedures and tests used to examine sexuality.
MNL LO: Analyze the concept of sexuality and its application to nursing care.

5) A female client complains of having a "strange discharge" from her vagina and "stinging" when voiding urine. Which diagnostic test(s) would be useful to aid in the diagnosis of this client's disorder? **Select all that apply.**

A) Biopsy
B) Urine culture
C) Pregnancy test
D) Serum hormone levels
E) Papanicolaou test

Answer: B, E

Explanation: A) A biopsy would not help diagnose the client’s problem.
B) The client is complaining of stinging with urination, so a urine culture would be helpful to rule out a urinary tract infection as the cause of the urinary pain.
C) This client's symptoms are not associated with pregnancy, so a pregnancy test would not be useful.
D) Serum hormone levels would not help diagnose the client’s problem.
E) The client is complaining of a strange discharge from the vagina, which may be indicative of infection. A Papanicolaou test would, therefore, be useful because it can diagnose certain types of infection.

Page Ref: 1513
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 19.6. Differentiate among common assessment procedures and tests used to examine sexuality.
MNL LO: Analyze the concept of sexuality and its application to nursing care.

6) The nurse is educating a group of teenage girls about the prevention of dating violence. Which statement should the nurse include in teaching?
A) "Studies suggest that males who monitor their partners' whereabouts are less likely to engage in violence than males who do not keep tabs on their partners."
B) "Females can reduce their risk of becoming victims of violence by adopting a submissive role in the dating relationship."
C) "Males who own weapons are no more likely to perpetrate dating violence than males who don't have access to weapons."
D) "Males with a history of aggressive behavior are more likely to behave violently toward their partners."
Answer: D
Explanation: A) Early warning signs that a male is at risk of perpetrating dating violence include jealous and possessive behaviors (such as monitoring a partner's whereabouts).
B) Encouraging women to act submissively not only places them at greater risk of violence but erodes their sense of agency and self-worth.
C) Early warning signs that a male is at risk of perpetrating dating violence include ownership of weapons.
D) Early warning signs that a male is at risk of perpetrating dating violence include a history of aggressive behavior.
Page Ref: 1517
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 19.5. Explain the promotion of healthy sexuality.
MNL LO: Analyze the concept of sexuality and its application to nursing care.

WwW.TbSH.Ws

7) An older adult client is having erections and wants to have sex but a partner does not have the same interest in sexual activity. Which response should the nurse make?
A) Explain that women lose interest in sex as part of the aging process.
B) Suggest that the client wait a while and the urge to have sex will pass.
C) Ask what the client has been doing to be sexually fulfilled.
D) Encourage the client to ask the partner to discuss the lack of interest in sexual activity with a healthcare provider.
Answer: D
Explanation: A) Lack of interest in sex is not a normal part of the aging process and suggests the partner is experiencing sexual dysfunction.
B) Suggesting that the client wait for the urge to pass is inappropriate.
C) Asking what the client is doing for sexual fulfillment is inappropriate.
D) The nurse's most appropriate course of action would be to encourage the client to ask the partner to discuss the lack of interest with a healthcare provider as a starting point.
Page Ref: 1497
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 19.9. Differentiate considerations related to the care of patients with alterations in sexuality throughout the lifespan.
MNL LO: Analyze the concept of sexuality and its application to nursing care.

8) During a vaginal examination, a woman's cervix and vaginal fornices are found to have a bluish cast to them. With which condition is this finding associated?
A) Menopause
B) Pregnancy
C) Pelvic infection
D) Anemia
Answer: B
Explanation: A) In some women, menopause may cause the vaginal mucosa to become pale and dry, but it would not result in bluish coloration.
B) A bluish color to the cervix and vaginal fornices may be a sign of pregnancy.
C) Pelvic infection is unlikely to cause the cervix or vaginal mucosa to take on a bluish tint.
D) A pale cervix would be suggestive of anemia.
Page Ref: 1512
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 19.6. Differentiate among common assessment procedures and tests used to examine sexuality.
MNL LO: Analyze the concept of sexuality and its application to nursing care.

9) Which sex therapy involves several stages of guided touching in which clients and their partners are encouraged to explore each other's bodies?
A) Progressive desensitization
B) Integrated therapy
C) Sensate focus
D) Directed masturbation
Answer: C
Explanation: A) Progressive desensitization is not a type of sex therapy.
B) Integrated sex therapy is a method that involves whatever combination of medical, behavioral, and cognitive techniques the provider(s) determine will be most beneficial to a client's particular problem.
C) Sensate focus is a type of sex therapy that involves several stages of guided touching. With this method, clients and their partners are encouraged to explore each other's bodies, beginning with areas other than the breasts and genitals, then gradually incorporating these areas as they progress to full intercourse.
D) Directed masturbation is similar to sensate focus, although it is used by clients who do not wish to have a partner participate in the therapeutic process.
Page Ref: 1515
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 19.8. Summarize collaborative therapies used by interprofessional teams for patients with alterations in sexuality.
MNL LO: Analyze the concept of sexuality and its application to nursing care.

10) For which reason is type 2 diabetes associated with an increased risk of sexual dysfunction in older adults?

A) Type 2 diabetes causes a decrease in sex hormone levels that may lead to diminished sexual function.

B) Type 2 diabetes contributes to arthritis and other joint problems that can make sexual activity difficult.

C) Type 2 diabetes brings about changes in cellular metabolism that may result in atrophy of the male and female reproductive organs.

D) Type 2 diabetes leads to vascular and nerve damage that may negatively affect sexual function.

Answer: D

Explanation: A) Although decreased sex hormone levels can contribute to sexual dysfunction in older adults, this condition is not related to type 2 diabetes.

B) Although arthritis and joint pain can contribute to sexual dysfunction in older adults, these conditions are not related to type 2 diabetes.

C) Type 2 diabetes does not contribute to atrophy of the reproductive organs.

D) Type 2 diabetes can cause both vascular damage and nerve damage that negatively affect sexual arousal and orgasm.

Page Ref: 1518

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 19.9. Differentiate considerations related to the care of patients with alterations in sexuality throughout the lifespan.

MNL LO: Analyze the concept of sexuality and its application to nursing care.

Exemplar 19.A Family Planning

1) The nurse educator is teaching a group of student nurses about problems of infertility and genetic inheritance of disease. Which statement made by a student nurse indicates that teaching has been effective?

A) "A person's genotype is the observable expression of their traits."

B) "The total genetic makeup of an individual is referred to as the phenotype."

C) "In an autosomal recessive inherited disorder, the individual must have two abnormal genes to be affected."

D) "An individual is said to have an autosomal dominant inherited disorder if the disease trait is homozygous."

Answer: C

Explanation: A) A person's genotype is their total genetic makeup.

B) A person's phenotype is the observable expression of their traits.

C) In an autosomal recessive inherited disorder, the individual must have two abnormal genes to be affected.

D) An individual is said to have an autosomal dominant inherited disorder if the disease trait is heterozygous–that is, the abnormal gene overshadows the normal gene of the pair to produce the trait.

Page Ref: 1524

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 19.A. Analyze family planning as it relates to sexuality. Describe the role of genetics in family planning.

MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient needing family planning.

2) The nurse is caring for a client who wants more information about fertility awareness-based contraceptive methods. Which statement made by the nurse provides the client with correct information?
A) "For women, the fertility window occurs between days 19 and 26 of the menstrual cycle."
B) "The calendar rhythm method is based on the assumption that ovulation tends to occur about 7 days before the start of a woman's next menstrual period."
C) "To use the calendar rhythm method, a woman must record her menstrual cycles for 6 months to identify the shortest and longest cycles."
D) "The calendar method is the most reliable fertility awareness-based method of contraception."
Answer: C
Explanation: A) For women, the fertility window occurs between days 8 and 19 of 26- to 32-day cycles.
B) The calendar rhythm method, also called the standard days method, is based on the assumption that ovulation tends to occur about 14 days before the start of a woman's next menstrual period.
C) Fertility awareness-based methods, also known as natural family planning, are based on an understanding of the changes that occur throughout a woman's ovulatory cycle. To use this method, the woman must record her menstrual cycles for 6 months to identify the shortest and longest cycles.
D) The calendar method is the least reliable of the fertility awareness methods.
Page Ref: 1525-1526
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 19.A. Analyze family planning as it relates to sexuality. Outline types of contraception used in family planning.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient needing family planning.

3) A female client wants to wait to start a family, even though her partner seems interested in having children in the near future. Which response should the nurse make when the client asks for advice?
A) "Maybe you should babysit a friend's child for a while to see whether you really want children."
B) "You and your partner need to discuss the decision to start a family."
C) "If you don't want to start a family, then you don't have to."
D) "What would you do if you became pregnant now?"
Answer: B
Explanation: A) Suggesting the client babysit a friend's child would be a strategy to help a person decide if they want to have a family, but it does not address the client and spouse's current issue.
B) Making the decision to have children is the first step a couple makes in the process of conception. Sometimes, one individual wishes to have a child but the other does not. In these situations, open discussion is essential to reach a mutually acceptable decision.
C) Telling the client that she does not need to start a family if she doesn't want to ignores the issue of the partner's desire for children.
D) Asking what the client would do if she became pregnant now does not address the client's desire to wait to start a family.
Page Ref: 1520
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 19.A. Analyze family planning as it relates to sexuality. Apply the nursing process in providing culturally competent care to an individual who needs family planning.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient needing family planning.

WwW.TbSx.Ws

4) A female client does not want to have children because there is a history of Down syndrome in her family. Which statement should the nurse make in response to this client?
A) "Down syndrome is the most common genetic defect caused by an extra chromosome."
B) "Babies born with Down syndrome do not live very long."
C) "It is probably best to not give birth to a baby with birth defects."
D) "Down syndrome only occurs in the babies of women who are over age 40."
Answer: A
Explanation: A) Down syndrome is the most common trisomy abnormality seen in children. It is the product of the union of a normal egg or sperm with an egg or sperm that has an extra chromosome.
B) Although children born with Down syndrome have a variety of physical ailments, advances in medical science have extended their life expectancy.
C) The nurse should not provide an opinion about giving birth to a baby with birth defects.
D) This syndrome can occur at any time in a childbearing client of any age.
Page Ref: 1522
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 19.A. Analyze family planning as it relates to sexuality. Describe the role of genetics in family planning.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient needing family planning.

5) During an evaluation for infertility, a male client is asked to provide a sperm sample. Which information from the client's health history could impact the quality and effectiveness of the client's sperm? **Select all that apply.**

A) Activity level
B) Smoking
C) Use of over-the-counter analgesics
D) Mumps after adolescence
E) Number of siblings

Answer: B, C, D

Explanation: A) Activity level is not used to evaluate the quality and effectiveness of a man's sperm.

B) The quality and effectiveness of sperm is affected by smoking history.

C) The quality and effectiveness of sperm is affected by use of over-the-counter medications.

D) The quality and effectiveness of sperm is affected by experiencing mumps after adolescence.

E) Number of siblings is not criteria to evaluate the quality and effectiveness of a man's sperm.

Page Ref: 1521

Cognitive Level: Analyzing

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 19.A. Analyze family planning as it relates to sexuality. Contrast family planning options.

MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient needing family planning.

6) During a health history, the nurse learns that a female client has been trying to conceive for 2 years and does not understand why she cannot become pregnant. For which risk factors for infertility should the nurse assess this client? **Select all that apply.**
A) Amount of alcohol consumed each day
B) Poor nutrition
C) Amount of exercise
D) Employment status
E) History of sexually transmitted infections
Answer: A, B, C, E
Explanation: A) Risk factors for female infertility include excess alcohol consumption.
B) Risk factors for female infertility include poor diet.
C) Risk factors for female infertility include excess athletic training.
D) Employment status is not a risk factor for female infertility.
E) Risk factors for female infertility include being infected with a sexually transmitted infection.
Page Ref: 1521
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 19.A. Analyze family planning as it relates to sexuality. Apply the nursing process in providing culturally competent care to an individual who needs family planning.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient needing family planning.

7) A client is prescribed an oral contraceptive that contains estrogen and progesterone. Which information should the nurse include when educating the client about this contraceptive? **Select all that apply.**
A) The estrogen portion of the contraceptive may cause an increase in appetite and subsequent weight gain.
B) The progesterone portion of the contraceptive may cause headaches and nausea.
C) Breast tenderness may occur when taking oral contraceptives that contain estrogen.
D) Taking an oral contraceptive that contains progesterone can lead to an increase in blood pressure.
E) Acne and oily skin are common side effects of the progesterone component in combined oral contraceptives.
Answer: C, E
Explanation: A) The progesterone portion may cause an increase in appetite and weight gain.
B) The estrogen component of these contraceptives may cause headaches and nausea.
C) The estrogen component of these contraceptives may cause breast tenderness.
D) The estrogen component of these contraceptives may cause an increase in blood pressure.
E) The progesterone portion may cause acne and oily skin.
Page Ref: 1533
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 19.A. Analyze family planning as it relates to sexuality. Outline types of contraception used in family planning.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient needing family planning.

8) The nurse is teaching a client with infertility about the medication clomiphene (Clomid). Which statement indicates to the nurse that teaching was effective?
A) "This medication increases the amount of gonadotropin-releasing hormone."
B) "This medication leads to increased levels of follicle-stimulating hormone."
C) "This medication stimulates the secretion of luteinizing hormone."
D) "This medication increases my estrogen levels so that I can ovulate."
Answer: C
Explanation: A) Clomiphene (Clomid) does not increase gonadotropin-releasing hormone.
B) Clomiphene (Clomid) does not stimulate secretion of FSH.
C) Clomiphene (Clomid) stimulates the secretion of luteinizing hormone (LH), resulting in the maturation of more ovarian follicles than would normally occur.
D) Clomiphene (Clomid) does not increase estrogen levels.
Page Ref: 1537
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 19.A. Analyze family planning as it relates to sexuality. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of individuals in need of family planning.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient needing family planning.

9) A client tells the nurse she plans to use oral contraceptives for birth control. Given this information, which client behavior would cause the nurse the most concern?

A) The client has several sexual partners.

B) The client is being treated for bipolar disorder.

C) The client smokes a pack of cigarettes each day.

D) The client drinks two glasses of wine per day.

Answer: C

Explanation: A) Having several sexual partners does not preclude the use of oral contraceptives, but the client should be advised that oral contraceptives do not provide protection against sexually transmitted infections so use of a barrier method is also recommended.

B) Being treated for bipolar disorder is not a contraindication for oral contraceptives.

C) Smoking while taking oral contraceptives increases the client's risk of developing a thrombolytic disorder.

D) Drinking two glasses of wine a day is not a contraindication to the use of oral contraceptives.

Page Ref: 1533

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 19.A. Analyze family planning as it relates to sexuality. Apply the nursing process in providing culturally competent care to an individual who needs family planning.

MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient needing family planning.

WwW.TeSM.Ws

10) A client wants to use the vaginal sponge as a method of contraception. Which statements indicate that the client needs further instruction about use of this method? **Select all that apply.**
A) "I should never leave the sponge in for more than 6 hours."
B) "I need to use a lubricant prior to insertion of the sponge."
C) "I can insert the sponge up to 24 hours before having sex."
D) "I need to add spermicidal cream to the sponge prior to having sex."
E) "I need to moisten the sponge with water prior to use."
Answer: A, B, D
Explanation: A) After insertion, the sponge can remain in place for up to 30 hours.
B) A lubricant is not needed, because the sponge is moistened with water prior to insertion.
C) After insertion, the sponge can remain in place for up to 30 hours.
D) Spermicidal cream is unnecessary because it is already in the sponge.
E) A lubricant is not needed because the sponge is moistened with water prior to insertion.
Page Ref: 1528
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 19.A. Analyze family planning as it relates to sexuality. Outline types of contraception used in family planning.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient needing family planning.

11) Which statement is *true* about women's sexual health during the postpartum period?
A) The lactational amenorrhea method is the most reliable form of contraception during the postpartum period, but only if a woman is breastfeeding exclusively.
B) Condoms and spermicides should not be used for contraception in the immediate postpartum period, because they increase a woman's risk for uterine infection.
C) Hormonal contraceptives can affect the quantity and quality of breast milk and increase the risk for deep vein thrombosis (DVT) if used in the first month after giving birth.
D) Women who use diaphragms as their primary means of contraception should be refitted for these devices no more than 6 weeks after giving birth.
Answer: C
Explanation: A) Clients who are breastfeeding exclusively may choose the lactational amenorrhea method (LAM). However, the effectiveness of LAM varies greatly, so women who use this method should be encouraged to consider a secondary method of contraception.
B) Condoms and spermicides are an excellent and safe option in the immediate postpartum period.
C) Hormonal contraceptives may be inappropriate because they can affect the quantity and quality of breast milk and increase the risk for DVT if used in the first month after giving birth.
D) Diaphragms should not be used until at least 6 weeks postpartum, at which time the woman will need to be refitted for a new device.
Page Ref: 1540
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 19.A. Analyze family planning as it relates to sexuality. Differentiate considerations for care of patients with regard to family planning across the lifespan.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient needing family planning.

12) For which reason would a healthcare provider most likely recommend that a 37-year-old pregnant woman seek prenatal genetic testing?
A) Because women over age 35 are at increased risk for gestational diabetes and other pregnancy complications
B) Because babies born to women over age 35 are at increased risk for chromosomal abnormalities
C) Because women over age 35 have a higher likelihood of giving birth to twins
D) Because women over age 35 are more likely to give birth to male children
Answer: B
Explanation: A) Although women over 35 are at increased risk for pregnancy complications, genetic screening does not reduce this risk.
B) Genetic testing is recommended for women over age 35 because of the increased risk of giving birth to a child with chromosomal abnormalities.
C) While women over age 35 are more likely to have twins, the presence of multiple embryos or fetuses can be determined without the need for genetic testing.
D) The likelihood of having a male or female child does not vary with maternal age.
Page Ref: 1523
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 19.A. Analyze family planning as it relates to sexuality. Differentiate considerations for care of patients with regard to family planning across the lifespan.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient needing family planning.

Exemplar 19.B Menopause

1) The nurse is caring for a client who is perimenopausal experiencing frequent bacterial vaginal infections. Which reason for these infections should the nurse include in the response to the client?
A) Decreased vaginal pH
B) Increased vaginal pH
C) Increased estrogen level
D) Decreased vasomotor stability
Answer: B
Explanation: A) During perimenopause, vaginal pH increases.
B) During perimenopause, vaginal pH increases, predisposing the client to bacterial vaginal infections.
C) During perimenopause, estrogen levels decrease, not increase.
D) Although decreased vasomotor stability is characteristic of perimenopause, it leads to hot flashes, not vaginal bacterial infections.
Page Ref: 1498
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 19.B. Analyze menopause as it relates to sexuality. Describe the physiology of menopause.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient experiencing menopause.

2) The nurse is caring for a client in menopause. When discussing hormone replacement therapy (HRT) with the client, the nurse should include which statement?
A) "Most healthy, recently menopausal women should not use HRT for relief of hot flashes and vaginal dryness."
B) "HRT is the least effective treatment of menopausal hot flashes and vaginal dryness."
C) "If vaginal dryness and painful intercourse are the only symptoms, then low-dose vaginal estrogen is preferred."
D) "The risk of blood clots in the legs or lungs is further increased by using transdermal patches, gels, or sprays."
Answer: C
Explanation: A) Most healthy, recently menopausal women may use HRT for relief of hot flashes and vaginal dryness.
B) HRT is used for hot flashes and vaginal dryness.
C) If vaginal dryness and dyspareunia (painful intercourse) are the only symptoms of menopause, then low-dose vaginal estrogen is preferred.
D) Risks for blood clots in the legs and lungs are increased with HRT, but occurrence is rare in women ages 50-59. The risk is further lowered by using low-dose estrogen pills or transdermal patches, gels, or sprays.
Page Ref: 1545
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 19.B. Analyze menopause as it relates to sexuality. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of a woman experiencing menopause.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient experiencing menopause.

3) A female client asks what causes the symptoms of menopause. On which hormonal function should the nurse focus when responding to this client's question?
A) Increased estradiol levels
B) Increased progesterone levels
C) Decreased estrogen levels
D) Increased luteinizing hormone levels
Answer: C
Explanation: A) As ovarian function decreases, estradiol is replaced by estrone as the major ovarian estrogen.
B) With decreased ovarian function, production of progesterone is also markedly reduced.
C) As ovarian function decreases, the production of estrogen decreases.
D) Although levels of luteinizing hormone increase, they are not the primary cause of the symptoms of menopause.
Page Ref: 1543
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 19.B. Analyze menopause as it relates to sexuality. Describe the physiology of menopause.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient experiencing menopause.

4) A client with a history of breast cancer who is entering menopause is seeking information about how to manage hot flashes. Which information should the nurse provide to the client?
A) Soy may be useful in reducing hot flashes, but researchers are still gathering evidence.
B) Hot flashes will continue until menopause is complete.
C) Estrogen is the only reliable treatment for hot flashes.
D) Black cohosh is effective in the management of hot flashes.
Answer: A
Explanation: A) Recent research suggests that soy is beneficial in reducing hot flashes during menopause; however, more evidence is needed before soy may be recommended as a treatment alternative.
B) Advising the client to wait until menopause is complete is inappropriate.
C) Estrogen is not the only reliable method of treatment for hot flashes, as estrogen/progestin combinations and SERMs have also proven useful in symptom reduction.
D) Black cohosh has been found to be ineffective in managing hot flashes.
Page Ref: 1547
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 19.B. Analyze menopause as it relates to sexuality. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of a woman experiencing menopause.

MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient experiencing menopause.

5) The nurse is assessing a postmenopausal client. Which client statement indicates the need for further assessment by the nurse?
A) "I use water-soluble lubricant to treat my vaginal dryness."
B) "For some reason, I have more sexual desire than ever."
C) "Sex certainly takes longer than it used to, but I'm getting used to that."
D) "I am so glad that I don't need to worry about sex anymore."
Answer: D
Explanation: A) Using vaginal lubricant reflects normal changes associated with aging and healthy responses to those changes.
B) Having more sexual desire reflects normal changes associated with aging and healthy responses to those changes.
C) Sex taking longer than it used to reflects normal changes associated with aging and healthy responses to those changes.
D) The statement "I am so glad that I don't need to worry about sex anymore" merits further assessment by the nurse. This statement is unclear. Does it mean that the client is glad she doesn't have to engage in sex anymore, or does it mean she is happy that she no longer has to worry about getting pregnant?
Page Ref: 1548
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 19.B. Analyze menopause as it relates to sexuality. Apply the nursing process for providing culturally competent care to a woman experiencing menopause.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient experiencing menopause.

6) A client who is premenopausal is not looking forward to menopause because it means her life is over. When the nurse asks what she means by this statement, the client says, "I can't imagine that anyone will have much use for an old woman who can't have children anymore." Based on this statement, which problem would most likely be appropriate for the client at this time?
A) Compromised sexuality
B) Lack of knowledge about menopause
C) Low self-esteem
D) Disturbed body image
Answer: C
Explanation: A) There is no information in the client's statement to support the problem of compromised sexuality.
B) The client may or may not have deficient knowledge.
C) The client believes that once she reaches menopause, her life is over. The most appropriate problem for the client at this time would be low self-esteem.
D) The client may or may not have a disturbed body image.
Page Ref: 1548
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 19.B. Analyze menopause as it relates to sexuality. Apply the nursing process for providing culturally competent care to a woman experiencing menopause.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient experiencing menopause.

7) A client who is approaching menopause is interested in oral hormone replacement therapy (HRT) to manage symptoms. Which point should the nurse include in this client's teaching plans?
A) HRT decreases a woman's risk for deep vein thrombosis.
B) HRT helps protect women against stroke and congestive heart failure.
C) HRT is often useful for women who are at increased risk for osteoporosis.
D) HRT is associated with a reduced incidence of breast cancer and pulmonary embolism.
Answer: C
Explanation: A) HRT is associated with increased incidence of deep vein thrombosis.
B) Although HRT was once thought to exert cardioprotective effects, several large studies suggest it may actually increase a woman's likelihood of stroke and congestive heart failure.
C) Estrogen has been shown to reduce a woman's risk of developing osteoporosis.
D) HRT is associated with increased incidence of breast cancer and pulmonary embolism.
Page Ref: 1546
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 19.B. Analyze menopause as it relates to sexuality. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of a woman experiencing menopause.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient experiencing menopause.

8) The nurse is evaluating care provided to a client who is experiencing menopause. Which observation indicates that the client is successfully managing the menopausal symptoms?
A) The client has lost 5 pounds in 4 months after starting an exercise program.
B) The client reports consuming about 800 mg of calcium per day.
C) The client has gained 8 pounds in 3 months despite regularly engaging in non-weight-bearing exercise.
D) The client states that she is "doing fine" so there's no need for her to keep talking about menopause.
Answer: A
Explanation: A) A weight loss of 5 pounds in 4 months after starting an exercise program is evidence of successful management of menopause.
B) The client should consume more than 800 mg of calcium a day.
C) Gaining weight does not indicate successful management of the symptoms of menopause.
D) Not wanting to discuss menopause does not indicate successful management of the condition.
Page Ref: 1549
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 19.B. Analyze menopause as it relates to sexuality. Apply the nursing process for providing culturally competent care to a woman experiencing menopause.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient experiencing menopause.

9) A client who is experiencing menopause expresses an interest in using alternative and complementary therapies to manage the symptoms. Which initial response by the nurse is most appropriate?
A) "What types of therapies are of interest to you?"
B) "Those therapies seldom work."
C) "Have you discussed this with your physician?"
D) "Many women report success with these measures."
Answer: A
Explanation: A) Alternative and complementary therapies are used by many women to manage the manifestations associated with menopause. Because the nurse has a responsibility to collect data from the client, the nurse will need to determine which of these therapies are of interest to the client.
B) It is inappropriate for the nurse to meet the client's request with negativity.
C) Although clients who use alternative therapies should be asked to report these therapies to their physician, making such a request should not be the nurse's initial step in this scenario.
D) The success of such remedies varies by user and by therapy.
Page Ref: 1547
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 19.B. Analyze menopause as it relates to sexuality. Apply the nursing process for providing culturally competent care to a woman experiencing menopause.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient experiencing menopause.

10) A client who is postmenopausal confides in the nurse that she has been experiencing pain during intercourse. Which suggestion should the nurse make to the client?
A) Use vaginal lubricants during intercourse.
B) Avoid intercourse.
C) Tolerate this problem because it is a normal part of aging.
D) Decrease the frequency of intercourse to decrease the pain.
Answer: A
Explanation: A) It is not uncommon for postmenopausal females to report painful intercourse related to a decrease in vaginal lubrication. Vaginal lubricants can be very effective in reducing pain during intercourse.
B) Avoiding sex would not resolve this client's problem.
C) It would be stereotypical for the nurse to assume the client has a reduced desire for intercourse because she is postmenopausal.
D) Decreasing the frequency of intercourse would not resolve this client's problem.
Page Ref: 1544
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 19.B. Analyze menopause as it relates to sexuality. Apply the nursing process for providing culturally competent care to a woman experiencing menopause.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient experiencing menopause.

11) Which clients would be described as experiencing premature ovarian failure (POF)?
A) A 29-year-old woman who is receiving chemotherapy that damages her ovaries
B) A 43-year-old woman who has irregular periods as a result of ovarian dysfunction
C) A 35-year-old woman who recently underwent an oophorectomy
D) A 32-year-old woman who does not ovulate because of an abnormally low number of ovarian follicles
Answer: D
Explanation: A) The client undergoing chemotherapy would be experiencing medical menopause.
B) Because of her age, the 43-year-old woman would not be considered to have POF.
C) The client with an oophorectomy would be experiencing surgical menopause.
D) Premature ovarian failure (POF), also known as premature menopause, occurs in women under the age of 40 who do not ovulate each month because of a low number of follicles or ovarian dysfunction.
Page Ref: 1547
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 19.B. Analyze menopause as it relates to sexuality. Differentiate considerations for care of patients with menopause across the lifespan.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient experiencing menopause.

12) Which statement is true with regard to surgical menopause and oophorectomy?
A) Natural conception is not an option for women who have undergone single oophorectomy.
B) Surgical menopause may be successfully treated with hormone replacement therapy.
C) Onset of surgical menopause is usually gradual.
D) Oophorectomy is always accompanied by either hysterectomy or salpingectomy.
Answer: B
Explanation: A) If oophorectomy involves one ovary, clients may still be able to conceive naturally.
B) Onset of surgical menopause is abrupt. Symptoms may be severe and may be treated with HRT.
C) Onset of surgical menopause is abrupt.
D) Oophorectomy may be done alone or may be combined with hysterectomy and/or salpingectomy.
Page Ref: 1547-1548
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 19.B. Analyze menopause as it relates to sexuality. Differentiate considerations for care of patients with menopause across the lifespan.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient experiencing menopause.

Exemplar 19.C Menstrual Dysfunction

1) Which statement is true regarding the etiology and pathophysiology of primary dysmenorrhea?
A) Primary dysmenorrhea is caused by decreased levels of prostaglandins, which cause uterine contractions to increase in strength.
B) Primary dysmenorrhea begins within 6 months after menarche.
C) Secondary dysmenorrhea is more common than primary dysmenorrhea.
D) Causes of primary dysmenorrhea include endometriosis, tumors, cysts, pelvic adhesions, pelvic inflammatory disease, infections, cervical stenosis, uterine leiomyomas, and adenomyosis.
Answer: B
Explanation: A) Primary dysmenorrhea is caused by the release of prostaglandins that cause the contractions of the uterus needed to expel menstrual fluid and tissue.
B) Primary dysmenorrhea begins within 6 months after menarche.
C) Secondary dysmenorrhea is related to pathology or diseases that affect the uterus and pelvic area.
D) Causes of secondary dysmenorrhea include endometriosis, tumors, cysts, pelvic adhesions, pelvic inflammatory disease, infections, cervical stenosis, uterine leiomyomas, and adenomyosis.
Page Ref: 1550-1551
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 19.C. Analyze menstrual dysfunction as it relates to sexuality. Describe the etiology of menstrual dysfunction.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with menstrual dysfunction.

2) The nurse is caring for a young adult client who reports painful periods. Which assessment findings suggest that this client is experiencing primary dysmenorrhea? **Select all that apply.**
A) Bleeding between menstrual periods
B) Headache
C) Fatigue
D) Diarrhea
E) Scant menses
Answer: B, C, D
Explanation: A) Bleeding between menstrual periods is characteristic of metrorrhagia.
B) Manifestations of primary dysmenorrhea include headache.
C) Manifestations of primary dysmenorrhea include fatigue.
D) Manifestations of primary dysmenorrhea include diarrhea.
E) Scant menses is a symptom of hormone imbalance.
Page Ref: 1551
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 19.C. Analyze menstrual dysfunction as it relates to sexuality. Identify the clinical manifestations of menstrual dysfunction.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with menstrual dysfunction.

3) The nurse is assessing the sexual health of a 20-year-old female client. Which findings should the nurse identify as risk factors for abnormal uterine bleeding? **Select all that apply.**
A) High level of stress
B) Weight gain of 20 pounds in 2 months
C) Use of birth control pills for contraception
D) History of peptic ulcer disease
E) Limited intake of high-fat foods
Answer: A, B, C
Explanation: A) A number of factors may predispose a woman to abnormal uterine bleeding. These factors include stress.
B) Extreme weight change is a risk factor for abnormal uterine bleeding.
C) Use of birth control pills for contraception is a risk factor for abnormal uterine bleeding.
D) Abnormal uterine bleeding is usually related to hormonal imbalances and not associated with peptic ulcer disease.
E) Abnormal uterine bleeding is usually related to hormonal imbalances and not associated with low-fat diets.
Page Ref: 1551
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 19.C. Analyze menstrual dysfunction as it relates to sexuality. Summarize risk factors and prevention of menstrual dysfunction.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with menstrual dysfunction.

4) A young adolescent client is concerned about experiencing severe cramps with menstruation and is concerned that something is wrong. Which response should the nurse make to the client?

A) "Menstrual cramping is not normal but is something that can be treated."

B) "You have cramps because you started your periods too early."

C) "Cramps are common in young women who just started having their periods, but they can be managed and often become less severe over time."

D) "You need to see a gynecologist for a pelvic examination."

Answer: C

Explanation: A) Cramps are common in this age range.

B) The client is an early adolescent, so she is in the normal age range to start having periods.

C) Primary dysmenorrhea occurs without specific pelvic pathology and is most often seen in girls who have just begun menstruating, usually becoming less severe after a woman's mid-20s.

D) The client does not need to see a gynecologist for a pelvic examination.

Page Ref: 1150-1151

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 19.C. Analyze menstrual dysfunction as it relates to sexuality. Differentiate considerations for care of patients with menstrual dysfunction across the lifespan.

MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with menstrual dysfunction.

5) The nurse is caring for a client who experiences severe dysmenorrhea. Which intervention should the nurse suggest to assist the client in coping with this disorder?
A) "Take frequent rest periods."
B) "Consider drinking 4 ounces of wine each day."
C) "Be sure to exercise and use relaxation techniques on a regular basis."
D) "Avoid contraception during menstruation when engaging in sexual intercourse."
Answer: C
Explanation: A) Frequent rest periods would be beneficial for a client with abnormal uterine bleeding but not a client with premenstrual syndrome.
B) Alcohol intake should be avoided, so the client should not be encouraged to have 4 ounces of wine each day.
C) Interventions to promote effective coping in a client with severe dysmenorrhea include encouraging exercise and use of relaxation techniques.
D) The client should be instructed to use contraception if engaging in sexual intercourse during menstruation because ovulation and pregnancy can occur.
Page Ref: 1551
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 19.C. Analyze menstrual dysfunction as it relates to sexuality. Apply the nursing process for providing culturally competent care to an individual with menstrual dysfunction.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with menstrual dysfunction.

6) The nurse is preparing to teach a group of young women about strategies for the relief of menstrual cramping. Which teaching point should be the focus of these strategies?
A) Minimizing menstrual flow
B) Avoiding uterine contraction
C) Increasing blood flow to the uterine muscle
D) Decreasing estrogen production
Answer: C
Explanation: A) There is no connection between pain and the actual amount of menstrual flow.
B) Mild uterine contractions (such as those associated with orgasm) can decrease pain and cramping.
C) Menstrual cramping is a result of muscle ischemia that occurs when the client experiences powerful uterine contractions. Increasing blood flow to the uterine muscle through rest, certain exercises, application of heat to the abdomen, and milder uterine contractions can decrease pain and cramping.
D) Estrogen production should follow normal patterns and should not be altered.
Page Ref: 1556
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 19.C. Analyze menstrual dysfunction as it relates to sexuality. Apply the nursing process for providing culturally competent care to an individual with menstrual dysfunction.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with menstrual dysfunction.

7) The nurse instructs a client on ways to reduce premenstrual difficulty. Which statement on the part of the client indicates that the instruction was beneficial?

A) "I need to increase dietary sugar intake to promote energy."

B) "Guided imagery does not help with premenstrual symptoms."

C) "I need to increase eating simple carbohydrates."

D) "I will reduce the amount of caffeine I drink."

Answer: D

Explanation: A) The intake of sugars should be reduced.

B) Guided imagery can be used to reduce stress and promote relaxation.

C) Intake of simple carbohydrates should be reduced.

D) The client stating that a reduction in caffeine intake will help reduce premenstrual difficulty is evidence that the instruction was beneficial.

Page Ref: 1551

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 19.C. Analyze menstrual dysfunction as it relates to sexuality. Apply the nursing process for providing culturally competent care to an individual with menstrual dysfunction.

MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with menstrual dysfunction.

8) Which interventions should the nurse recommend to a client who is experiencing primary dysmenorrhea? **Select all that apply.**
A) Increase caffeine intake.
B) Use a heating pad.
C) Try relaxation techniques.
D) Engage in regular exercise.
E) Avoid vitamin supplements.
Answer: B, C, D
Explanation: A) Caffeine intake should be restricted to reduce irritability.
B) A heating pad can help reduce abdominal cramping and pain.
C) Relaxation techniques may be useful because they promote the release of pain-relieving endorphins.
D) Regular aerobic activity helps decrease dysmenorrhea symptoms.
E) Vitamin supplements should not be avoided and may be needed to help control symptoms.
Page Ref: 1551, 1556
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 19.C. Analyze menstrual dysfunction as it relates to sexuality. Apply the nursing process for providing culturally competent care to an individual with menstrual dysfunction.

MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with menstrual dysfunction.

9) In what way does menometrorrhagia differ from menorrhagia?
A) Menometrorrhagia involves excessive menstruation, whereas menorrhagia does not.
B) Menometrorrhagia involves irregular menstruation, whereas menorrhagia does not.
C) Menometrorrhagia involves prolonged menstruation, whereas menorrhagia does not.
D) Menometrorrhagia involves the absence of menstruation, whereas menorrhagia does not.
Answer: B
Explanation: A) Menorrhagia is excessive menstruation.
B) Menorrhagia occurs at regular intervals, Menometrorrhagia is irregular menstruation.
C) Menorrhagia is prolonged menstruation, Menometrorrhagia is irregular, excessive, prolonged menstruation. It is essentially a combination of the heavy bleeding of menorrhagia and the irregularity of metrorrhagia.
D) Neither menorrhagia nor menometrorrhagia cause the absence of menstruation.
Page Ref: 1552
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. |
Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 19.C. Analyze menstrual dysfunction as it relates to sexuality. Identify the clinical manifestations of menstrual dysfunction.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with menstrual dysfunction.

10) Which condition is the lack of menarche by age 16?
A) Amenorrhea
B) Oligomenorrhea
C) Dysmenorrhea
D) Metrorrhagia
Answer: A
Explanation: A) Amenorrhea is the absence of menstruation by age 16.
B) Oligomenorrhea is light or infrequent menstruation and occurs when cycles are longer than 35 days with less than 9 periods in a year.
C) Dysmenorrhea is pain with menses.
D) Metrorrhagia is bleeding of variable amount between menstrual periods.
Page Ref: 1552
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 19.C. Analyze menstrual dysfunction as it relates to sexuality. Identify the clinical manifestations of menstrual dysfunction.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with menstrual dysfunction.

Exemplar 19.D Sexual Dysfunction

1) The nurse is collecting the health history of a client with erectile dysfunction (ED). Which finding(s) could indicate a possible cause for the client's ED? **Select all that apply.**
A) Blood pressure of 118/68 mmHg
B) Treatment for type 2 diabetes mellitus for 7 years
C) Body mass index (BMI) of 24.5
D) Alcohol intake of 4 to 6 beers each day
E) Engaging in moderate exercise twice a week
Answer: B, D
Explanation: A) A normal blood pressure would not provide a possible cause for the client's recent experience with ED.
B) Risk factors for ED include diseases such as diabetes.
C) A body mass index within normal limits would not provide a possible cause for the client's recent experience with ED.
D) Excessive use of alcohol can result in erectile dysfunction.
E) Engaging in moderate exercise would not provide a possible cause for the client's recent experience with ED.
Page Ref: 1559
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Summarize sexual dysfunctions experienced by men.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

2) A 30-year-old client is concerned about impotence after experiencing difficulty sustaining an erection during a recent sexual encounter. Which response should the nurse make?
A) "An occasional incident like this is normal and common."
B) "Sexually transmitted infections may result in sexual problems in adults."
C) "Erectile dysfunction is the correct term for inability to achieve or sustain an erection."
D) "A medical diagnosis of erectile dysfunction is not made until a man has experienced erectile difficulties for a period of at least 3 months."
Answer: A
Explanation: A) This client is concerned about impotence. The best response is that this is common and normal for men to experience occasional erectile difficulties.
B) Even though STIs can cause sexual problems, this does not address the client’s concern.
C) Correcting the client's use of medical terminology does not address his concerns.
D) Stating when a medical diagnosis of erectile dysfunction is made does not address the client’s concern.
Page Ref: 1559
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Summarize sexual dysfunctions experienced by men.

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MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

3) A male client questions why his spouse wants to continue the marriage since not being able to perform sexually after having prostate surgery. Which problem should the nurse use to plan this client’s care?
A) Difficulty coping
B) Low self-esteem
C) Imbalances in hormone levels
D) Sexual dysfunction
Answer: B
Explanation: A) The information does not indicate the client is having difficulty coping with the situation.
B) This statement suggests that the client's inability to perform sexually is causing him to question his self-worth. Low self-esteem is the most appropriate problem to plan care for this client.
C) There is no evidence that the client has a hormone imbalance.
D) Sexual dysfunction is associated with anxiety concerning the cause of the dysfunction, which is not the case for this client.
Page Ref: 1567
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Apply the nursing process for providing culturally competent care to an individual with sexual dysfunction.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

4) Which information should the nurse include in the plan of care for a client experiencing erectile dysfunction due to a chronic health condition? **Select all that apply.**
A) Information about herbal supplements that can help treat ED
B) Information on prescription medications used in ED treatment
C) Brief description of types of devices and surgeries available to help with ED
D) Explanation of how to discontinue any prescribed medications that may be contributing to the client's ED
E) Information on the exact cause of the client's ED
Answer: B, C
Explanation: A) Discussing herbal supplements would be inappropriate because none of these substances have been found to be effective in the treatment of ED.
B) When planning care for a client with ED related to a chronic health condition, the nurse should include information on medications for treatment.
C) When planning care for a client with ED related to a chronic health condition, the nurse should include information on types of devices and surgeries available to help with the disorder.
D) The nurse should not encourage the client to discontinue any medications that may be causing sexual side effects; rather, the nurse should advise the client to discuss these medications with his provider before stopping treatment or pursuing other medication options.
E) Because an exact cause of the client's ED may be difficult to determine, this information would not be appropriate for the nurse to include in the plan of care.
Page Ref: 1567
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Apply the nursing process for providing culturally competent care to an individual with sexual dysfunction.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

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5) The nurse is instructing a client about the medication sildenafil (Viagra). Which statement on the part of the client indicates that this teaching has been effective?
A) "Viagra should be taken with food."
B) "I can take Viagra at the same time I take my daily alpha-adrenergic blocker."
C) "I can take only one pill in a 24-hour period."
D) "Viagra works by decreasing blood flow to the penis."
Answer: C
Explanation: A) Sildenafil (Viagra) does not need to be taken with food.
B) Sildenafil (Viagra) should not be used by men who are taking alpha-adrenergic blockers.
C) Sildenafil (Viagra) should be taken no more than once per day.
D) Sildenafil (Viagra) acts by facilitating relaxation of smooth muscle in the penis, thus allowing increased blood flow.
Page Ref: 1564
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with sexual dysfunction.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

6) The nurse is caring for a client with erectile dysfunction (ED). Which medication(s) should the nurse anticipate being prescribed for this client? **Select all that apply.**
A) Sildenafil (Viagra)
B) Methylphenidate (Ritalin)
C) Vardenafil (Levitra)
D) Buspirone (BuSpar)
E) Tadalafil (Cialis)
Answer: A, C, E
Explanation: A) Sildenafil (Viagra) is a medication that acts by facilitating relaxation of smooth muscle in the penis, thus allowing increased blood flow and erection.
B) Methylphenidate (Ritalin) is a mild central nervous system stimulant and is not effective for ED.
C) Vardenafil (Levitra) is a medication that acts by facilitating relaxation of smooth muscle in the penis, thus allowing increased blood flow and erection.
D) Buspirone (BuSpar) is an antianxiety agent and is not effective in the treatment of ED.
E) Tadalafil (Cialis) is a medication that acts by facilitating relaxation of smooth muscle in the penis, thus allowing increased blood flow and erection.
Page Ref: 1564
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with sexual dysfunction.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

7) A client asks for a prescription for tadalafil (Cialis). Which question should the nurse ask the client prior to creating a plan of care?
A) "Do you have diabetes mellitus?"
B) "Are you comfortable taking this medication twice per day?"
C) "Do you have any sexually transmitted infections?"
D) "Do you use nitroglycerine?"
Answer: D
Explanation: A) Diabetes mellitus is not a contraindication to the use of Cialis.
B) Cialis should be taken no more than once per day.
C) Tadalafil (Cialis) is not contraindicated in a person with an STI.
D) Tadalafil (Cialis) should not be used by clients who are taking nitroglycerine and other nitrate-based drugs.
Page Ref: 1564
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with sexual dysfunction.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

8) A male client reports having difficulty ejaculating during sexual activity. Which condition should the nurse suspect the client is experiencing?
A) Retrograde ejaculation
B) Delayed ejaculation
C) Erectile dysfunction
D) Male hypoactive sexual desire disorder
Answer: B
Explanation: A) In retrograde ejaculation, ejaculation occurs but the fluid travels into the bladder instead of out through the urethra.
B) Delayed ejaculation involves extreme difficulty ejaculating, despite the ability to maintain an erection for long periods.
C) Erectile dysfunction is an inability to attain or maintain an erection sufficient to permit mutually satisfactory sexual intercourse with a partner.
D) Male hypoactive sexual desire disorder involves a deficiency in or absence of sexual fantasies and persistently low interest or a total lack of interest in sexual activity.
Page Ref: 1560
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: IX.3. Implement holistic, patient-centered care that reflects an understanding of human growth and development, pathophysiology, pharmacology, medical management and nursing management across the health-illness continuum, across lifespan, and in all healthcare settings. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Summarize sexual dysfunctions experienced by men.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

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9) A 45-year-old female client reports having no interest in sex for about 8 months and has also had difficulty with arousal. Which response by the nurse is best?
A) "Don't worry; all women go through periods where they are uninterested in sex."
B) "It sounds like you might be experiencing female sexual interest/arousal disorder, although your symptoms need to be present for 12 full months before this diagnosis applies."
C) "You are not alone. Lack of interest and arousal is the most common sexual problem reported by female clients."
D) "A lack of interest in sex is a normal consequence of the aging process, and it often begins around the time a woman enters menopause."
Answer: C
Explanation: A) A total or near-total lack of interest in sex is not typical and is likely indicative of a larger problem.
B) A diagnosis of female sexual interest/arousal disorder may be appropriate when a woman experiences decreased or absent sexual thoughts, interest in sexual activity, mental or physical feelings of arousal, and/or pleasurable sensation during sexual activity at least 75% of the time for a period of 6 months or more.
C) Female sexual interest/arousal disorder is the most common female sexual dysfunction.
D) A lack of interest in sex is not a normal consequence of the aging process.
Page Ref: 1561
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Summarize sexual dysfunctions experienced by women.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

10) The nurse is planning care for a client with female orgasmic disorder. Which action would *least* likely be included in the client's plan of care?
A) Referral to a sex therapist
B) Information on the use of vibrators and other mechanical aids
C) Teaching on how to perform pelvic floor exercises
D) Instruction on how to obtain and use vaginal dilators
Answer: D
Explanation: A) A variety of treatment options may be useful for women affected by female orgasmic disorder, including sex therapy.
B) A variety of treatment options may be useful for women affected by female orgasmic disorder, including use of vibrators and other mechanical aids.
C) A variety of treatment options may be useful for women affected by female orgasmic disorder, including instruction regarding exercises that strengthen the pelvic floor.
D) Vaginal dilators are used in the treatment of genito-pelvic pain/penetration disorder, not female orgasmic disorder.
Page Ref: 1565-1566
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with sexual dysfunction.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

11) The nurse is teaching a client about sexual activity during pregnancy. Which client statement indicates that this teaching has been successful?
A) "The elevated androgen levels that accompany pregnancy might reduce my desire for sex."
B) "It's a good idea to avoid vaginal sex during the last few weeks of pregnancy, so I don't risk hurting the baby."
C) "Sexual dysfunction is uncommon during pregnancy, although many women suffer from low desire during the postpartum period."
D) "Pregnant women are most likely to experience sexual difficulties during the third trimester."
Answer: D
Explanation: A) Some sexual difficulties are related to the decreased androgen levels of pregnancy.
B) Although some women fear that penetration will harm the fetus, this is rarely the case.
C) Between 60% and 70% of women experience sexual dysfunction during pregnancy, and an even higher percentage report difficulties during the postpartum period.
D) Sexual problems during pregnancy often fluctuate by trimester. The third trimester is the time when sexual difficulties are most common.
Page Ref: 1566
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Differentiate considerations for care of patients with sexual dysfunction across the lifespan.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

12) A client who delivered 10 weeks ago via cesarean section reports difficulty resuming sexual relations because of reduced desire for sex and pain upon penetration. Which response should the nurse make?
A) "Are you breastfeeding? If so, switching to formula will help resolve these issues."
B) "Most women don't report these sorts of problems unless they've delivered vaginally."
C) "These problems are common during the postpartum period and usually resolve with time."
D) "Based on the symptoms you're reporting, I'm concerned you might be experiencing a postpartum mood disorder."
Answer: C
Explanation: A) Although the hormonal changes associated with breastfeeding may contribute to sexual difficulties, the client should be encouraged to continue breastfeeding for the health of the infant.
B) Both reduced desire and sexual pain are common during the postpartum period, regardless of a vaginal or cesarean birth.
C) Typically, these problems resolve within several months.
D) Even though clients with postpartum mood disorders are at increased risk for sexual dysfunction, such dysfunction is not necessarily indicative of a postpartum mood disorder.
Page Ref: 1566
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Differentiate considerations for care of patients with sexual dysfunction across the lifespan.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

13) A client who is postmenopausal reports losing interest in sex as a normal part of aging. Which problem should the nurse use to plan care for this client?
A) Low self-esteem
B) Ineffective sexuality patterns
C) Inadequate relationship skills
D) Lack of knowledge
Answer: D
Explanation: A) Nothing in the client's statement suggests low self-esteem.
B) There is no evidence that the client is experiencing an ineffective sexuality pattern.
C) Nothing in the client's statement indicates that relationship issues are a factor in this situation.
D) Although some declines in desire and arousal are normal with age, a total or near-total lack of interest in sex is not typical and is likely indicative of a larger problem. Because the client seems unaware of this fact, the client lacks knowledge.
Page Ref: 1567
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Differentiate considerations for care of patients with sexual dysfunction across the lifespan.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

14) A 25-year-old client taking a selective serotonin reuptake inhibitor (SSRI) for depression reports decreased sexual desire since starting the medication. Which medication should the nurse anticipate being prescribed for this client??

A) Addition of bupropion to the client's drug regimen

B) Immediate discontinuation of fluoxetine therapy

C) Addition of flibanserin to the client's drug regimen

D) Switch the type of SSRI

Answer: A

Explanation: A) SSRI antidepressants are frequently associated with a range of sexual side effects, including reduced desire. Providers may prescribe the atypical antidepressant bupropion (Wellbutrin) along with SSRI therapy, as bupropion can exert desire-increasing effects.

B) Abrupt discontinuation of an SSRI is not advisable because it can exacerbate a client's depression.

C) Although flibanserin is the only FDA-approved medication specifically aimed at the treatment of low desire in women, it is rarely prescribed and would not be a provider's first treatment option in this scenario.

D) Switching the type of SSRI will not help the client’s problem.

Page Ref: 1562

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with sexual dysfunction.

MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

15) Which term describes involuntary tightening of the pelvic muscles that prevents penetration from occurring?
A) Female orgasmic disorder
B) Vaginismus
C) Genito-pelvic pain/penetration disorder
D) Dyspareunia
Answer: B
Explanation: A) Female orgasmic disorder is the persistent delay or absence of orgasm following a phase of normal sexual excitement.
B) In women, vaginismus is involuntary tightening of the pelvic muscles that prevents penetration from occurring.
C) Although often associated with genito-pelvic pain/penetration disorder, vaginismus is not necessary for this diagnosis.
D) Dyspareunia is pain experienced by a woman during vaginal penetration.
Page Ref: 1562
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 19.D. Analyze sexual dysfunctions as they relate to sexuality. Summarize sexual dysfunctions experienced by women.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with sexual dysfunction.

Exemplar 19.E Sexually Transmitted Infections

1) The nurse is conducting a history and physical assessment of a sexually active teenage client. Which findings should the nurse identify as consistent with genital herpes? **Select all that apply.**
A) Low blood pressure
B) Headache
C) Fever
D) Dysuria
E) Vaginal discharge
Answer: B, C, D, E
Explanation: A) Low blood pressure is not a manifestation of genital herpes.
B) Manifestations of genital herpes include flulike symptoms such as a headache.
C) Manifestations of genital herpes include flulike symptoms including a fever.
D) Manifestations of genital herpes include dysuria.
E) Manifestations of genital herpes include a vaginal discharge.
Page Ref: 1570
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 19.E. Analyze sexually transmitted infections (STIs) as they relate to sexuality. Outline clinical manifestations and therapies of selected STIs.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with a sexually transmitted infection.

2) The nurse is assessing a client who has an open sore on his penis. Which question by the nurse best elicits additional data related to this finding?
A) "Do you think you have a disease?"
B) "Have you had sexual intercourse recently?"
C) "Are you promiscuous?"
D) "When did you initially notice this open area?"
Answer: D
Explanation: A) Asking if the client is concerned about having a disease is a closed question and will not elicit much information.
B) Determining the date of the last episode of sexual intercourse might be indicated later if a disease is diagnosed.
C) Asking the client about promiscuity is judgmental.
D) It is important that the nurse record the onset of the open area.
Page Ref: 1573
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 19.E. Analyze sexually transmitted infections (STIs) as they relate to sexuality. Apply the nursing process for providing culturally competent care to an individual with an STI.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with a sexually transmitted infection.

3) A client is experiencing dysuria, urinary frequency, and vaginal discharge. For which sexually transmitted infection(s) should the nurse prepare the client for testing? **Select all that apply.**
A) Syphilis
B) HIV
C) Chlamydia
D) Human papillomavirus (HPV)
E) Gonorrhea
Answer: C, E
Explanation: A) Syphilis does not cause the client’s symptoms.
B) HIV does not cause the client’s symptoms.
C) Chlamydia creates the manifestations of dysuria, urinary frequency, and discharge.
D) HPV does not cause the client’s symptoms.
E) Gonorrhea creates the manifestations of dysuria, urinary frequency, and discharge.
Page Ref: 1570-1571
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 19.E. Analyze sexually transmitted infections (STIs) as they relate to sexuality. Outline clinical manifestations and therapies of selected STIs.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with a sexually transmitted infection.

4) A client with a sexually transmitted infection (STI) reports having "no idea" how the illness was contracted. Which problem would be appropriate for the client at this time?
A) Anxiety
B) Lack of knowledge about STIs
C) Inadequate coping
D) Sexual dysfunction
Answer: B
Explanation: A) There is not enough information provided to determine if the client is anxious.
B) The client's statement indicates deficient knowledge regarding the transmission of sexually transmitted infections.
C) There is not enough information provided to determine if the client is not able to cope.
D) There is no evidence that the client has sexual dysfunction.
Page Ref: 1573
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 19.E. Analyze sexually transmitted infections (STIs) as they relate to sexuality. Apply the nursing process for providing culturally competent care to an individual with an STI.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with a sexually transmitted infection.

5) The nurse is planning care for a client with gonorrhea who also has a history of prior sexually transmitted infections (STIs). Which action is a priority for this client?

A) Instruction about the need to avoid all future sexual contact
B) A plan for the client to contact sexual partners regarding the diagnosis
C) Recommendation that the client increase fluids and rest
D) Teaching regarding the importance of adequate nutrition

Answer: B

Explanation: A) The nurse should instruct the client to avoid sexual contact until recovered from the current illness, but not necessarily to avoid all future sexual contact.

B) The client has gonorrhea and a history of sexually transmitted infections. The nurse should, therefore, encourage the client to develop a plan for contacting sexual partners regarding the diagnosis.

C) Increasing fluids and rest, are important, but not as important as contacting sexual partners to protect their health and limit the spread of disease.

D) Good nutrition is important but not as important as contacting sexual partners to protect their health and limit the spread of disease.

Page Ref: 1571

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 19.E. Analyze sexually transmitted infections (STIs) as they relate to sexuality. Apply the nursing process for providing culturally competent care to an individual with an STI.

MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with a sexually transmitted infection.

6) The nurse is providing education to sexual partners about the importance of treatment for a chlamydia infection. Which client statements indicate this teaching was effective? **Select all that apply.**

A) "Chlamydia can cause inflammation of the tube that carries urine from the bladder to outside the body."

B) "Severe vaginal itching can be a consequence of chlamydia."

C) "Rashes commonly occur with this disease."

D) "Chlamydia can spread to the uterus and fallopian tubes and result in infertility."

E) "Chlamydia can result in pregnancy complications."

Answer: A, D, E

Explanation: A) In men, chlamydia is a major cause of nongonococcal urethritis.

B) Chlamydia does not cause vaginal itching.

C) Chlamydia does not cause a rash.

D) In women, chlamydia cervicitis can ascend and become pelvic inflammatory disease, or infection of the uterus, fallopian tubes, and sometimes ovaries.

E) Pregnant women with an untreated chlamydia infection are at greater risk of developing complications such as miscarriage, premature birth, or stillbirth.

Page Ref: 1570

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 19.E. Analyze sexually transmitted infections (STIs) as they relate to sexuality. Outline clinical manifestations and therapies of selected STIs.

MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with a sexually transmitted infection.

7) A client with genital herpes asks the nurse how to manage pain when urinating and difficulty voiding. Which response by the nurse is correct?
A) "Try to limit your fluid intake. That way, you won't have to void so often."
B) "Pouring room-temperature water over your genitals may make it easier for you to start urinating."
C) "Be sure to keep your genitals as dry as possible. Unnecessary exposure to water can worsen your infection and cause even greater pain upon urination."
D) "Unfortunately, there's nothing you can do to eliminate your discomfort. It won't go away until your current herpes outbreak is over."
Answer: B
Explanation: A) Drinking additional fluids helps dilute the urine and reduce the burning sensation when voiding.
B) Clients with genital herpes who complain of dysuria and difficulty voiding can be taught to pour water over the genitals to start urination and dilute the urine.
C) The nurse might suggest the use of sitz baths (with tepid water) for 15-30 minutes several times a day.
D) Warm water is soothing and decreases pain from ulcers and an irritated urethral meatus. It facilitates wound healing and facilitates urination.
Page Ref: 1574
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 19.E. Analyze sexually transmitted infections (STIs) as they relate to sexuality. Apply the nursing process for providing culturally competent care to an individual with an STI.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with a sexually transmitted infection.

8) The nurse is planning care to address pain in a client with genital herpes. Which intervention would most be appropriate for this plan of care?
A) Do not submerge lesions in water.
B) Clean lesions two or three times a day with warm water and soap.
C) Dry lesions with a hair dryer turned to the hot setting.
D) Wear tight cotton clothing.
Answer: B
Explanation: A) Tepid sitz baths are useful in decreasing pain from ulcers and an irritated urethral meatus.
B) Measures to reduce the discomfort of herpes lesions include cleansing the lesions two or three times a day with warm water and mild soap.
C) Lesions should be dried using a hair dryer turned to the cool setting.
D) Wearing loose cotton clothing will not trap moisture.
Page Ref: 1574
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 19.E. Analyze sexually transmitted infections (STIs) as they relate to sexuality. Apply the nursing process for providing culturally competent care to an individual with an STI.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with a sexually transmitted infection.

9) A public health nurse is educating a group of adults about the incidence and prevalence of sexually transmitted infections (STIs). Which statement should be included?

A) "Males have higher rates of gonorrhea and chlamydia, whereas women have higher rates of syphilis."

B) "Men are disproportionately affected by STIs as compared to women and infants."

C) "Women often experience few early manifestations of infection, which causes them to delay diagnosis and treatment."

D) "The incidence of STIs is highest among young Caucasian females."

Answer: C

Explanation: A) Women have higher rates of gonorrhea, whereas men have higher rates of chlamydia and syphilis.

B) Women and infants are disproportionately affected by STIs as compared to men.

C) Women often experience few early manifestations of sexually transmitted infection, which can lead to delays in diagnosis and treatment.

D) STIs affect men and women of all ages, backgrounds, and socioeconomic levels.

Page Ref: 1572

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 19.E. Analyze sexually transmitted infections (STIs) as they relate to sexuality. Describe the epidemiology of STIs.

MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with a sexually transmitted infection.

10) A college student is being treated for chlamydia. Which information should the nurse teach this student to decrease the risk of transmitting another sexually transmitted infection?
A) Unprotected sex is acceptable if you know the partner well.
B) Latex condoms should be used for all sexual activity.
C) Birth control pills will help decrease the risk of pregnancy and STDs.
D) Condoms should be used with petroleum jelly.
Answer: B
Explanation: A) Unprotected sex should only be considered when both partners have been tested for STIs and the relationship is mutually monogamous.
B) Latex condoms should be used for all sexual activity to decrease the risk of contracting and/or spreading a sexually transmitted infection.
C) Although birth control pills can decrease the risk of pregnancy, they do not protect against the transmission of sexually transmitted infections.
D) Petroleum jelly can damage a condom, defeating its purpose for safe sex.
Page Ref: 1569
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 19.E. Analyze sexually transmitted infections (STIs) as they relate to sexuality. Apply the nursing process for providing culturally competent care to an individual with an STI.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with a sexually transmitted infection.

11) Which statement is true with regard to sexually transmitted infections (STIs) and older adults?
A) Because pregnancy is no longer a concern, older adults may not use condoms, thereby increasing their risk of STIs.
B) Normal age-related changes to the body put older adults at reduced risk of contracting STIs.
C) STIs are rare among older adults because of decreased levels of sexual activity among the members of this population.
D) Healthcare providers should avoid discussing STIs with older clients unless these clients initiate the conversation.
Answer: A
Explanation: A) Because pregnancy is no longer a concern, older adults may not use condoms or may use them inconsistently.
B) Normal age-related changes to the body can put older adults at greater risk of infection.
C) Older adults are living longer, healthier lives and are engaging in sex more than in previous generations. Along with this increase in sexual activity comes an increase in STIs.
D) Providers play a key role in STI prevention by acknowledging that continuation of sexual activity is a normal part of aging, encouraging clients to talk about their sexual practice, dispelling myths about the risk of infection, and providing information that is relevant to older clients.
Page Ref: 1573
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 19.E. Analyze sexually transmitted infections (STIs) as they relate to sexuality. Differentiate considerations for care of patients with STIs across the lifespan.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with a sexually transmitted infection.

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12) Which action should the nurse take when caring for an 8-year-old client who is exhibiting the symptoms of a sexually transmitted infection (STI)?
A) Immediately perform a detailed examination and collect relevant specimens.
B) Assume that the child acquired the infection during the perinatal period.
C) Initiate presumptive treatment of the STI as soon as possible.
D) Anticipate the need to follow mandatory reporting guidelines.
Answer: D
Explanation: A) It is essential to examine and collect specimens from children in a manner that minimizes trauma to them; thus, examination and collection should be conducted by a clinician with specific experience in the area of child sexual abuse.
B) In some cases, STIs in young children may be the result of perinatally acquired infections that can persist for 2 to 3 years; however, the general rule is to consider infection evidence of abuse.
C) STI testing should be conducted prior to initiating treatment of children exhibiting STI symptoms in order to obtain a reliable diagnosis.
D) Because STIs in children are often a result of sexual abuse, and also because public health authorities require the reporting of certain STIs, the nurse should anticipate the need to follow mandatory reporting guidelines.
Page Ref: 1572
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 19.E. Analyze sexually transmitted infections (STIs) as they relate to sexuality. Differentiate considerations for care of patients with STIs across the lifespan.
MNL LO: Demonstrate understanding of the concept of sexuality in the care of a patient with a sexually transmitted infection.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 20 Thermoregulation

The Concept of Thermoregulation

1) The nurse is caring for a client who experienced a boating accident in which the client nearly drowned. Which type of heat loss caused hypothermia in this client?
A) Evaporation
B) Insensible water loss
C) Convection
D) Insensible heat loss
Answer: C
Explanation: A) Evaporation is the process of converting water to a vapor, and the evaporation of sweat transfers the heat in the sweat to the air.
B) Insensible water loss is unnoticed water loss through evaporation.
C) Convection is the process of heat transfer through the fluid motion of air or water across the skin. The victim of a boating accident developed hypothermia through convection.
D) Insensible heat loss is the loss of heat through evaporation.
Page Ref: 1582
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 20.1. Analyze the physiology of thermoregulation.
MNL LO: Analyze the concept of thermoregulation and its application to nursing care.

2) During an assessment, the nurse notes that a client who was a victim of an industrial accident has a mildly elevated body temperature. When discussing the client's increased temperature, which will the nurse attribute it to?

A) Infection

B) Diet

C) Exercise

D) Stress

Answer: D

Explanation: A) There is no evidence presented to indicate infection. The client was not exercising. Diet does not influence body temperature.

B) Diet does not influence body temperature.

C) Factors that affect body temperature include age, diurnal variations, exercise, hormones, stress, and environment. However, the client who is a victim of an industrial accident most likely has a temperature elevation because of stress.

D) The client who is a victim of an industrial accident most likely has a temperature elevation because of stress.

Page Ref: 1589

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 20.3. Outline the relationships between thermoregulation and other concepts.

MNL LO: Analyze the concept of thermoregulation and its application to nursing care.

3) A client is experiencing an elevated temperature due to a viral illness. Which actions should the nurse anticipate being included in this client's plan of care? **Select all that apply.**

A) Administer warm intravenous fluids.
B) Apply warm blankets.
C) Keep limbs close to body.
D) Increase fluid intake.
E) Administer antipyretic medication.

Answer: D, E

Explanation: A) Warm IV fluids help a client with a low body temperature.
B) Warm blankets help a client with a low body temperature.
C) Keeping the limbs close to the body helps a client with a low body temperature.
D) The client has an elevated temperature. Increasing fluid intake is an intervention for an elevated body temperature.
E) The client has an elevated temperature. The administration of antipyretic medication is one treatment used to lower the body temperature.

Page Ref: 1584
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 20.6. Analyze independent interventions nurses can implement for patients with alterations in thermoregulation.
MNL LO: Analyze the concept of thermoregulation and its application to nursing care.

4) The nurse needs to assess the body temperature of a client who has just smoked a cigarette and consumed hot coffee. Which temperature assessment method should the nurse use?
A) Axillary
B) Temporal artery
C) Tympanic
D) Rectal
Answer: C
Explanation: A) The axillary method takes a long time if an accurate measurement is to be obtained.
B) The temporal artery method requires special electronic equipment.
C) Since the oral method cannot be used because the client smoked a cigarette and consumed hot coffee, the assessment method of choice would be the tympanic membrane. This method is readily accessible and reflects the core temperature very quickly.
D) The rectal method is inconvenient and uncomfortable for clients.
Page Ref: 1587
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 20.5. Differentiate among common assessment procedures and tests used to examine thermoregulation.

MNL LO: Analyze the concept of thermoregulation and its application to nursing care.

5) A client is admitted with the diagnosis of fever of unknown origin. Which diagnostic test does the nurse anticipate for this client?
A) CT scan of the abdomen
B) Bone scan
C) Glucose tolerance test
D) Complete blood count
Answer: D
Explanation: A) A CT scan of the abdomen may or may not be indicated for this client.
B) A bone scan or may not be indicated for this client.
C) A glucose tolerance test may or may not be indicated for this client.
D) The diagnostic tests will focus on trying to find the cause of the elevated body temperature. The complete blood count will be done to see if there is an elevation in white blood cells, indicative of infection.
Page Ref: 1588
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 20.5. Differentiate among common assessment procedures and tests used to examine thermoregulation.
MNL LO: Analyze the concept of thermoregulation and its application to nursing care.

6) The nurse is caring for a client admitted with minor burns and elevated body temperature after being in a house fire. Which actions should be included in this client's plan of care to address the elevated body temperature? **Select all that apply.**
A) Providing blankets
B) Keeping the room temperature warm
C) Restricting fluids
D) Encouraging fluids
E) Lowering room temperature
Answer: D, E
Explanation: A) Blankets would be applicable if the client had a low body temperature.
B) Providing a warm room would be applicable if the client had a low body temperature.
C) The client's fluids should not be restricted.
D) The client with an elevated body temperature should be encouraged to ingest fluids or should be provided with IV fluids. The increase in body temperature could be due to dehydration.
E) Another intervention to help the client with an elevated temperature is to lower the room temperature.
Page Ref: 1584
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 20.6. Analyze independent interventions nurses can implement for patients with alterations in thermoregulation.
MNL LO: Analyze the concept of thermoregulation and its application to nursing care.

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7) An older adult client with pneumonia has the following vital signs: P 84, R 22, BP 118/74, T (oral) 98.3°F. Which response should the nurse make when the client asks why a fever has not developed?
A) The cool temperature of the hospital room helps prevent fevers.
B) The client was likely misdiagnosed and does not have an infection.
C) The body's ability to respond to changes in temperature declines with age.
D) The loss of body heat associated with pneumonia reduces the risk of fever.
Answer: C
Explanation: A) It is not known whether the room is or is not cold.
B) A normal body temperature does not indicate that the client does not have pneumonia.
C) Older adults' temperatures may not be a valid indication of an infectious process. Other symptoms such as confusion and restlessness may be more accurate indicators.
D) The client may or may not be losing body heat.
Page Ref: 1593
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 20.8. Differentiate considerations related to the care of patients with alterations in thermoregulation across the lifespan.

MNL LO: Analyze the concept of thermoregulation and its application to nursing care.

8) The nurse is providing care to a client who is experiencing an elevated body temperature. Which class of medication does the nurse anticipate will be prescribed for this client?
A) Anticholinergic
B) Antihypertensive
C) Antiemetic
D) Antipyretic
Answer: D
Explanation: A) Anticholinergics reduce acetylcholine activity.
B) Antihypertensives are used to reduce blood pressure.
C) Antiemetics are used to reduce nausea and vomiting.
D) Antipyretic medication is used to reduce the body temperature.
Page Ref: 1590
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 20.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in thermoregulation.
MNL LO: Analyze the concept of thermoregulation and its application to nursing care.

9) The nurse is caring for a client who is experiencing hyperthermia. Which intervention is appropriate for this client?
A) Applying warm blankets
B) Administering a prescribed antipyretic medication
C) Keeping limbs close to the body
D) Covering the scalp with a hat
Answer: B
Explanation: A) Applying warm blankets is for a client experiencing hypothermia.
B) Hyperthermia is the medical term for an increase in body temperature. An appropriate intervention for a client experiencing hyperthermia is to administer a prescribed antipyretic medication, such as acetaminophen.
C) Keeping the limbs close to the body is appropriate for a client experiencing hypothermia.
D) Covering the scalp with a hat is for a client who is experiencing hypothermia.
Page Ref: 1584
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 20.6. Analyze independent interventions nurses can implement for patients with alterations in thermoregulation.
MNL LO: Analyze the concept of thermoregulation and its application to nursing care.

10) The nurse assists with the examination of a newborn in the newborn nursery. For which heat loss is the nurse preventing by placing a pad on the surface of the examination table?
A) Convection
B) Conduction
C) Evaporation
D) Radiation
Answer: B
Explanation: A) Convection is the process of heat transfer through the fluid motion of air or water across the skin.
B) Conduction is the process of heat transfer through physical contact of one surface to another surface. This is the method of heat loss that occurs when a newborn baby is placed on a bare surface.
C) Evaporation is the process of converting water to a vapor.
D) Radiation is the process of heat transfer with no physical contact.
Page Ref: 1592
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 20.8. Differentiate considerations related to the care of patients with alterations in thermoregulation across the lifespan.
MNL LO: Analyze the concept of thermoregulation and its application to nursing care.

11) The nurse is asked to explain thermoregulation. Which response should the nurse make?
A) "Core temperature varies widely depending on the outside environment."
B) "The body's surface temperature remains relatively constant."
C) "Chemical thermogenesis occurs with the increase of cortisol."
D) "All muscle activity, regardless of location, produces heat."
Answer: D
Explanation: A) Core temperature remains relatively constant.
B) The body's surface temperature varies widely depending on the outside environment.
C) Chemical thermogenesis occurs with increased output of thyroxine, not cortisol.
D) All muscle activity, regardless of location, produces heat.
Page Ref: 1582
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 20.1. Analyze the physiology of thermoregulation.
MNL LO: Analyze the concept of thermoregulation and its application to nursing care.

12) Which hormone is responsible for epinephrine release and affects chemical thermogenesis?
A) Norepinephrine
B) Thyroxine
C) Progesterone
D) Aldosterone
Answer: B
Explanation: A) Norepinephrine does not cause epinephrine release.
B) Increased thyroxine levels cause an increase in the release of epinephrine.
C) Progesterone maintains pregnancy and is not involved in chemical thermogenesis.
D) Aldosterone regulates electrolyte and water balance and does not affect chemical thermogenesis.
Page Ref: 1582
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 20.1. Analyze the physiology of thermoregulation.
MNL LO: Analyze the concept of thermoregulation and its application to nursing care.

13) A client is brought for emergency care for a core body temperature of 88.8°F. In which way should the nurse categorize this client?
A) Normothermic
B) Mildly hyperthermic
C) Febrile
D) Moderately hypothermic

Answer: D
Explanation: A) Normothermia occurs when body temperature falls between 96.8°F and 101.3°F.
B) Hyperthermia occurs when body temperature is above 101.3°F.
C) A hyperthermic patient may be described as febrile.
D) Hypothermia occurs when core body temperature is below 95°F and is classified as moderate between 82.4°F and 89.6°F.
Page Ref: 1583
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 20.2. Differentiate among alterations in thermoregulation.
MNL LO: Analyze the concept of thermoregulation and its application to nursing care.

14) In the past, a college campus in a cold climate has had multiple students require treatment for mild hypothermia during the winter months. Which method would be most effective for the campus nurse to use to promote healthy thermoregulation on this campus?

A) Show a video about the harmful effects of hypothermia due to exposure.

B) Put up posters encouraging students to wear hats and mittens.

C) Sell inexpensive pocket handwarmers in the campus bookstore.

D) Send emails telling students that alcohol consumption prevents hypothermia.

Answer: A

Explanation: A) College students are mostly likely to pay attention to a video compared to other media choices, and showing a video about the harmful effects of hypothermia due to exposure may be effective for many students who wouldn't pay attention to the other options.

B) College students are likely to ignore posters telling them to wear hats and mittens.

C) Students may not have money to purchase handwarmers, and they may not even know they are available for purchase in the bookstore without some advertisement.

D) Alcohol consumption increases the risk of exposure due to poor choices, which then increases the risk for hypothermia.

Page Ref: 1587

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

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Learning Outcome: 20.4. Explain the promotion of thermoregulation.

MNL LO: Analyze the concept of thermoregulation and its application to nursing care.

Exemplar 20.A Hyperthermia

1) A client is started on antibiotic therapy for a respiratory infection. Which goal is appropriate for this client?
A) The client will have no evidence of sweating.
B) The client's mucous membranes will be dry.
C) The client's temperature will be within normal limits within 48 to 72 hours of the administration of the antibiotic.
D) The client's temperature will approach normal within 60 minutes of the administration of the antibiotic.
Answer: C
Explanation: A) Sweating is evidence that the temperature is decreasing, a desired outcome.
B) Dry mucous membranes are evidence of an elevated temperature and are not a desired outcome.
C) A goal of care for a client receiving antibiotic therapy for an infection is for the temperature to be within normal limits within 48 to 72 hours after starting the antibiotic.
D) The temperature approaching normal within 60 minutes would be an appropriate goal if the client were receiving antipyretics.
Page Ref: 1599
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 20.A. Analyze hyperthermia as it relates to thermoregulation. Apply the nursing process for providing culturally competent care to an individual with hyperthermia.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hyperthermia.

2) A client is receiving care for an elevated body temperature. Which assessment findings indicate that care has been effective? **Select all that apply.**

A) Urine output of 20 mL/hour
B) Moist mucous membranes
C) Heart rate of 120 beats per minute
D) Good skin turgor
E) Blood pressure of 118/68 mmHg

Answer: B, D

Explanation: A) Urine output of 20 mL/hour indicates dehydration.
B) Evidence that interventions have been effective for a client with an elevated body temperature includes moist mucous membranes.
C) A heart rate of 120 beats per minute could indicate dehydration.
D) Evidence that interventions have been effective for a client with an elevated body temperature includes good skin turgor.
E) Blood pressure of 118/68 mmHg is not an indication of the control of fever.

Page Ref: 1559

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 20.A. Analyze hyperthermia as it relates to thermoregulation. Apply the nursing process for providing culturally competent care to an individual with hyperthermia.

MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hyperthermia.

3) A client who works outside in the sun seeks medical attention for a body temperature of 103°F. Which actions should the nurse take when caring for this client? **Select all that apply.**

A) Use warm blankets.
B) Restrict fluids.
C) Apply cool washcloths to the face and neck.
D) Assess vital signs.
E) Remove or loosen clothing around the neck and chest.

Answer: C, E

Explanation: A) Warm blankets would keep the temperature elevated rather than helping to decrease it.

B) Restricting fluids would keep the temperature elevated rather than helping to decrease it.

C) Until the client has orders written, the nurse can apply cool washcloths to the client's face and neck to increase comfort and reduce the client's body temperature.

D) Assessing vital signs is important; however, the nurse needs to intervene to help bring the body temperature down.

E) The nurse can reduce clothing and skin covering by loosening clothing around the neck and chest.

Page Ref: 1590

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 20.A. Analyze hyperthermia as it relates to thermoregulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hyperthermia.

MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hyperthermia.

4) A hospitalized client with a body temperature of 104°F is entering the flush phase of the fever. Which action by the nurse is appropriate when providing care?
A) Restricting fluids
B) Monitoring intake and output
C) Covering the client with warm blankets
D) Providing warmed intravenous fluids
Answer: B
Explanation: A) Restricting fluids could lead to dehydration and a higher body temperature.
B) During the flush phase of a fever, the client's body is attempting to adjust the temperature set-point lower. Nursing measures are implemented in order to aid the body in reestablishing a core temperature compatible with normal cellular functioning. The nurse must diligently monitor the client's intake and output to address changes in hydration state.
C) Warm blankets will increase the body's temperature.
D) Warm intravenous fluids will increase the body's temperature.
Page Ref: 1595
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 20.A. Analyze hyperthermia as it relates to thermoregulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hyperthermia.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hyperthermia.

5) A school-age client has a temperature of 101°F with a normal appearance and few signs of discomfort. Which statement should the nurse include when instructing the mother on treatment of the fever?

A) "Place the child in a cold bath."
B) "Administer aspirin by either chewable tablet or liquid suspension."
C) "It is not necessary to treat the fever at this point."
D) "If your child is shivering, it is okay to use several blankets to decrease discomfort."

Answer: C

Explanation: A) The child may be placed in a tepid, not cold, bath.
B) Aspirin should not be given to children due to its link to Reye syndrome.
C) Fever is not inherently harmful until it reaches 41°C (105.8°F). For this reason, medical management may include postponing treatment of low-grade fevers–those under 38.9°C (102°F) in otherwise healthy children.
D) Reducing clothing and blankets, not additional layers, aids in the treatment of fever.

Page Ref: 1596
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 20.A. Analyze hyperthermia as it relates to thermoregulation. Differentiate considerations for care of patients with hyperthermia across the lifespan.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hyperthermia.

6) The nurse is caring for a client with a fever who is experiencing tachypnea. Which is true regarding this client's condition?
A) The decrease in prostaglandin production causes the respiratory rate to increase.
B) Although it sometimes occurs, an increased respiratory rate is not a common reaction to fever.
C) One degree of temperature elevation causes an increase in respiratory rate by two breaths per minute.
D) One degree of temperature elevation causes an increase in respiratory rate by four breaths per minute.
Answer: D
Explanation: A) Prostaglandin production increases, not decreases, during fever.
B) Increased respiratory rate always occurs with a fever.
C) Every one degree of temperature elevation causes an increase in respiratory rate of four breaths per minute.
D) Every one degree of temperature elevation causes an increase in respiratory rate of four breaths per minute.
Page Ref: 1594
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 20.A. Analyze hyperthermia as it relates to thermoregulation. Describe the pathophysiology of hyperthermia.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hyperthermia.

7) The nurse is caring for a 73-year-old client. When assessing temperature, which finding would the nurse report immediately to the provider as a potential sign of sepsis?
A) The client's temperature is below his baseline temperature.
B) The client's temperature is above his baseline temperature.
C) The client's temperature is at his baseline temperature.
D) The client's temperature is fluctuating with each measurement.
Answer: A
Explanation: A) Older adults frequently do not present with a fever that coincides with the significance of an infection, and, in fact, temperatures below the older adult's baseline may accompany sepsis.
B) Sepsis in an older adult is not associated with an elevated temperature.
C) Sepsis in an older adult causes a lower temperature and not one at the baseline.
D) The temperature will not fluctuate in an older adult with sepsis.
Page Ref: 1598
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 20.A. Analyze hyperthermia as it relates to thermoregulation. Differentiate considerations for care of patients with hyperthermia across the lifespan.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hyperthermia.

8) A 31-year-old pregnant client in the second trimester has a fever of 102°F and is concerned that the unborn child is at risk. Which statement should the nurse include when explaining the client's risk?
A) "Maternal fever is only problematic when it reaches 103° or higher, but temperatures below this level are generally not a concern."
B) "Maternal fever is not associated with birth defects; rather, the medication taken to reduce the fever may cause problems."
C) "Maternal fever is a concern during pregnancy, but the risk to the child is greatest during the first trimester."
D) "Maternal fever is not associated with birth defects, but other types of hyperthermic exposure are associated with them."
Answer: C
Explanation: A) A temperature of 101.3° or greater is considered a fever.
B) Studies indicate that it is the fever itself–not medication or maternal illness–that is associated with such defects.
C) Hyperthermic exposure and maternal fever in the first trimester of pregnancy have been associated with congenital defects.
D) Hyperthermic exposure and maternal fever in the first trimester of pregnancy have been associated with congenital defects.
Page Ref: 1598
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 20.A. Analyze hyperthermia as it relates to thermoregulation. Differentiate considerations for care of patients with hyperthermia across the lifespan.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hyperthermia.

WwW.TeBSM.Ws

9) For which reason should the nurse monitor interval vital sign measurements to assess for hyperthermia in the clinical setting?
A) They are useful for monitoring for infection and inflammation.
B) They are important for establishing a client's baseline temperature.
C) They are essential to determining the cause of a fever of unknown origin.
D) They are helpful for monitoring a client's reaction to antipyretics.
Answer: A
Explanation: A) The nurse should use interval vital sign measurement to monitor for infections and inflammation, which are common causes of fever.
B) Interval vital signs are not used to establish a baseline temperature.
C) Interval vital signs are not used to determine the cause of a fever of unknown origin.
D) Interval vital signs are not used to monitor the response to antipyretics.
Page Ref: 1595
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 20.A. Analyze hyperthermia as it relates to thermoregulation. Compare risk factors and prevention of hyperthermia.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hyperthermia.

10) When flushing occurs in a client with a fever, what underlying mechanism to restore normal temperature is occurring?
A) Increased metabolism
B) Vasodilation
C) Insensible water loss
D) Increased thyroxine output
Answer: B
Explanation: A) Flushing does not mean metabolism is increasing.
B) Flushing is redness of the skin that occurs when blood vessels vasodilate in order to bring more blood flow to the body's surface. This allows the air's cooler temperature to reduce the temperature of the blood flow as heat dissipates through convection.
C) Flushing is not caused by insensible water loss.
D) Flushing is not caused by increased thyroxine output.
Page Ref: 1595
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 20.A. Analyze hyperthermia as it relates to thermoregulation. Identify the clinical manifestations of hyperthermia.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hyperthermia.

Exemplar 20.B Hypothermia

1) A client is admitted to the emergency department complaining of the inability to feel the hands and feet after exposure to 20°F temperatures for more than 2 hours. Which action by the nurse is appropriate?
A) Warm the hands and feet in 104°F water for 20 to 30 minutes.
B) Provide an antipyretic.
C) Rub and massage the hands and feet.
D) Warm the hands and feet in tepid water for 2 hours.
Answer: A
Explanation: A) The client's inability to feel his hands and feet after spending 2 hours in 20°F weather would indicate the client is experiencing frostbite. Rapid thawing decreases tissue necrosis and should be done by warming the hands and feet in circulating 104°F water for 20 to 30 minutes.
B) Antipyretics would be indicated for a fever.
C) The hands and feet should not be rubbed.
D) Tepid water will not rapidly warm the hands and feet.
Page Ref: 1603
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 20.B. Analyze hypothermia as it relates to thermoregulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hypothermia.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hypothermia.

2) A young adult client is admitted to the emergency department with symptoms of hypothermia. Which data collected during the health history supports this diagnosis?
A) The client was wearing a coat when the EMTs found him.
B) The client had a blood alcohol level of 0.12.
C) The client forgot to eat lunch.
D) The client was wearing a winter hat at the time of admission.
Answer: B
Explanation: A) Wearing a coat is a way to prevent hypothermia.
B) Alcohol causes peripheral vasodilation, which exposes the circulating bloodstream to more rapid cooling, resulting in a faster decrease in body temperature. The client's intake of alcohol contributed to the development of hypothermia.
C) Skipping a meal would not cause hypothermia.
D) Wearing a hat would prevent hypothermia.
Page Ref: 1602
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 20.B. Analyze hypothermia as it relates to thermoregulation. Compare risk factors and prevention of hypothermia.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hypothermia.

3) The nurse is educating a family who is planning an ice fishing trip on ways to prevent hypothermia. Which recommendation by the nurse is appropriate?
A) All family members should wear skid-proof footwear.
B) If someone becomes hypothermic, sponge tepid water onto any exposed skin.
C) All family members should wear light rain jackets.
D) If someone becomes hypothermic, remove any wet clothing, wrap the person in blankets, and have the person drink a warm liquid.
Answer: D
Explanation: A) Skid-proof footwear will not prevent hypothermia.
B) Tepid water is used in cases of hyperthermia, not hypothermia
C) Light rain jackets will not prevent hypothermia.
D) First aid for hypothermia includes moving the person to a dry area, removing wet clothing, protecting the person from further environmental exposure, wrapping the person in dry blankets, dressing the person in warm, dry clothing, and having the person drink a warm, high-calorie liquid.
Page Ref: 1603
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 20.B. Analyze hypothermia as it relates to thermoregulation. Compare risk factors and prevention of hypothermia.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hypothermia.

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4) A client has a body temperature of 96°F and exhibits slurred speech and poor coordination. Which is the priority problem for this client?

A) Anxiety
B) Altered cognition
C) Potential change in vital signs
D) Change in cardiovascular status

Answer: B

Explanation: A) Anxiety is not identified as a problem with a low body temperature.
B) The client with hypothermia is at risk for altered cognition.
C) The main problem in the client is not a potential change in vital signs.
D) Change in cardiovascular status is not the main problem in the client with hypothermia.

Page Ref: 1605

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 20.B. Analyze hypothermia as it relates to thermoregulation. Apply the nursing process for providing culturally competent care to an individual with hypothermia.

MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hypothermia.

5) The nurse is planning to instruct a new mother on ways to prevent hypothermia in her newborn. Which information should this teaching include?
A) Expect the baby to shiver.
B) Keep the newborn's head covered with a hat.
C) Cover the newborn with a light sheet during afternoon naps.
D) Cover the newborn with minimal blankets when out of doors in temperatures in the 50s.
Answer: B
Explanation: A) Shivering is not expected and means that the baby's metabolic rate has doubled.
B) Covering the newborn's head will help reduce heat loss.
C) The newborn should be swaddled in a blanket of appropriate weight during naps.
D) The newborn should be swaddled in a blanket of appropriate weight when outdoors in cool temperatures.
Page Ref: 1606
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 20.B. Analyze hypothermia as it relates to thermoregulation. Differentiate considerations for care of patients with hypothermia across the lifespan.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hypothermia.

6) A client has been receiving treatment for hypothermia. Which evaluation finding indicates nursing interventions have been successful?

A) Current temperature of 95°F

B) Heart rate of 72 and regular

C) Continues to shiver

D) Blood pressure of 88/54 mmHg

Answer: B

Explanation: A) A temperature of 95°F indicates a continued low body temperature.

B) Evidence of successful treatment for hypothermia is a heart rate of 72 (which is within normal limits) and regular.

C) Shivering indicates a continued low body temperature.

D) A low blood pressure indicates a continued low body temperature.

Page Ref: 1606

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 20.B. Analyze hypothermia as it relates to thermoregulation. Apply the nursing process for providing culturally competent care to an individual with hypothermia.

MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hypothermia.

7) A client is admitted with a core body temperature of 93°F. Which action by the nurse is appropriate for this client?
A) Apply warm soaks to the extremities.
B) Use a hypothermia blanket.
C) Provide warm fluids.
D) Use warm blankets.
Answer: D
Explanation: A) Warm soaks to extremities will not raise the client's body temperature and might cause chilling.
B) A hypothermia blanket is used when treating hyperthermia, not hypothermia.
C) Providing warm fluids is beneficial, but not enough to raise the client's body temperature.
D) For mild hypothermia, or a body temperature of 89.6-95°F, use warm blankets.
Page Ref: 1603
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 20.B. Analyze hypothermia as it relates to thermoregulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hypothermia.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hypothermia.

8) The nurse is providing care to a client who has a body temperature of 94°F, an irregular heart rate, and low blood pressure. Which action should the nurse take?
A) Elevate the client's legs.
B) Provide a heating pad to the client's lower back.
C) Elevate the head of the bed.
D) Administer warmed intravenous fluids.
Answer: D
Explanation: A) Elevating the legs will not help with the client's hypothermia.
B) A heating pad to the lower back is not indicated in the treatment of hypothermia.
C) Elevating the head of the bed will not help with the client's hypothermia.
D) The client is mildly hypothermic with symptoms of an irregular heartbeat and low blood pressure. Warmed intravenous fluids would be beneficial for this client.
Page Ref: 1590
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 20.B. Analyze hypothermia as it relates to thermoregulation. Apply the nursing process for providing culturally competent care to an individual with hypothermia.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hypothermia.

9) A nurse is working in the labor and delivery unit. Which information does the nurse include to explain newborn thermogenesis?
A) Shivering occurs when skin receptors perceive a drop in the environmental temperature and transmit sensations to stimulate the sympathetic nervous system.
B) Shivering thermogenesis uses the newborn's stores of brown fat to provide heat.
C) Brown fat produces heat generation and heat transfer to the peripheral circulation.
D) The extra muscular activity by the infant in cold stress produces a large amount of body heat.
Answer: C
Explanation: A) In the infant, non-shivering thermogenesis (NST) occurs when skin receptors perceive a drop in the environmental temperature and transmit sensations to stimulate the sympathetic nervous system.
B) NST uses the newborn's stores of brown fat to provide heat.
C) Brown fat produces heat generation and heat transfer to the peripheral circulation.
D) The extra muscular activity by the infant in cold stress does not produce body heat.
Page Ref: 1604
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 20.B. Analyze hypothermia as it relates to thermoregulation. Differentiate considerations for care of patients with hypothermia across the lifespan.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hypothermia.

10) A nurse is caring for a client with hypothermia and frostbite of the nose and fingers. Which action by the nurse is inappropriate for this client?
A) Massage frostbite areas to rewarm them and increase circulation.
B) Rapidly rewarm affected areas in circulating warm water.
C) Keep the client on bedrest with the affected parts elevated.
D) Debride blisters.
Answer: A
Explanation: A) A nurse should never massage frostbite areas, as this action will further damage necrotic tissue.
B) Rapid rewarming in circulating warm water is appropriate.
C) Keeping the client on bedrest is appropriate.
D) Debriding blisters is appropriate.
Page Ref: 1603
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 20.B. Analyze hypothermia as it relates to thermoregulation. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with hypothermia.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hypothermia.

11) The nurse is reviewing the medical records of clients. Which client should the nurse identify as having the *lowest* risk for developing hypothermia?
A) An 80-year-old client with hypothyroidism and a lengthy medication regimen
B) A 69-year-old client with type 2 diabetes mellitus and peripheral neuropathy
C) A 75-year-old client with decreased subcutaneous fat and several dietary restrictions
D) A 78-year-old client who regularly walks and does strength training with small hand weights
Answer: D
Explanation: A) Chronic conditions such as hypothyroidism increase the risk.
B) Chronic conditions such as diabetes and peripheral neuropathy increase the risk.
C) Decreased subcutaneous fat increases the risk.
D) Lack of activity is an environmental risk factor for hypothermia in older results, so the active older adult is at a lower risk for hypothermia.
Page Ref: 1605
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 20.B. Analyze hypothermia as it relates to thermoregulation. Differentiate considerations for care of patients with hypothermia across the lifespan.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hypothermia.

12) A client who has experienced head trauma may undergo induced hypothermia for which purpose?
A) Reduce metabolic rate and oxygen need
B) Reduce the risk of internal bleeding
C) Reduce the risk of a brain hemorrhage
D) Reduce glycogen consumption
Answer: A
Explanation: A) Hypothermia is induced following head trauma to reduce metabolic rates and lower cellular demand for oxygen in the tissues, particularly the brain. Historically, this reduces neurologic damage.
B) The risk of internal bleeding is not reduced.
C) The risk of hemorrhage is not reduced.
D) Glycogen needs are increased in hypothermia.
Page Ref: 1601
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 20.B. Analyze hypothermia as it relates to thermoregulation. Describe the etiology of hypothermia.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hypothermia.

13) Which approach should be used to assess the severity of hyperthermia?
A) Core temperature measurement
B) Skin temperature measurement
C) Clinical presentation of the client
D) Client history related to current condition
Answer: C
Explanation: A) Severity of hypothermia should not be determined based on temperature measurement, as methods of measuring temperature and degree of accuracy may differ.
B) Severity of hypothermia should not be determined based on temperature measurement, as methods of measuring temperature and degree of accuracy may differ.
C) Clinical presentation of the client should determine the severity of hypothermia, and all clients diagnosed with hypothermia should undergo a complete body survey.
D) History may be useful for determining causative factors, but not severity of condition.
Page Ref: 1603
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 20.B. Analyze hypothermia as it relates to thermoregulation. Identify the clinical manifestations of hypothermia.
MNL LO: Demonstrate understanding of the concept of thermoregulation in the care of a patient with hypothermia.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 21 Tissue Integrity

The Concept of Tissue Integrity

1) The nurse is caring for an older adult. Which age-related changes should the nurse identify as increasing the risk of dry skin? **Select all that apply.**
A) Reduction in elastin
B) Depleted moisture in epidermal cells
C) Decreased size of sebaceous glands
D) Thinner subcutaneous skin layer
E) Poor nutrition
Answer: B, C, E
Explanation: A) Reduction in elastin leads to wrinkling and sagging of the skin.
B) As the individual ages, moisture transfer from the dermis to the epidermis declines. This contributes to a dry, rough skin appearance.
C) Sebaceous glands also decrease in size with age, resulting in skin that is dry and easily bruised, damaged, or broken.
D) The older adult's thinner subcutaneous skin layer increases the risk for hypothermia and pressure ulcer formation.
E) Poor nutrition could also cause dry skin.
Page Ref: 1637
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.8. Differentiate considerations related to the care of patients with alterations in tissue integrity throughout the lifespan.
MNL LO: Analyze the concept of tissue integrity and its application to nursing care.

2) The nurse observes flakes of greasy white dandruff in a client's hair. The nurse should correctly identify this as which type of secondary lesion?
A) Nodule
B) Macule
C) Scales
D) Crusts
Answer: C
Explanation: A) A nodule is a primary skin lesion.
B) A macule is a primary skin lesion.
C) Scales are flakes of greasy, keratinized skin tissue that vary in color from white, to gray, to silver. An example of this type of skin lesion is dandruff.
D) A crust is an area of dry blood, serum, or pus left on the skin surface when vesicles or pustules break.
Page Ref: 1650
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.2. Differentiate alterations in tissue integrity.
MNL LO: Analyze the concept of tissue integrity and its application to nursing care.

3) The nurse presses a finger into swollen skin tissue on a client's feet and ankles and notes that it creates an indentation. The nurse should correctly document a finding of which alteration in skin integrity?
A) Poor turgor
B) Ascites
C) Peripheral edema
D) Hypothermia
Answer: C
Explanation: A) Skin turgor is the skin's elasticity and is assessed by gently pinching the skin over the sternum or collarbone.
B) Ascites is abdominal swelling.
C) Excess fluid trapped in bodily tissue, such as the feet and ankles, creates edema. To assess for the amount of edema, the nurse presses a finger into the edematous area to create an indentation. The amount of indentation indicates the level of edema.
D) Skin temperature is assessed through palpation.
Page Ref: 1629
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 21.5. Differentiate among common assessment procedures and tests used to examine tissue integrity.
MNL LO: Analyze the concept of tissue integrity and its application to nursing care.

4) A client has an excoriated skin area with purulent drainage. Which diagnostic test does the nurse anticipate being ordered?
A) Skin biopsy
B) Culture
C) Wood's lamp
D) Patch test
Answer: B
Explanation: A) Skin biopsies are used to differentiate a benign skin lesion from a skin cancer.
B) Cultures to identify infections may be conducted on tissue samples, on drainage and exudates from lesions, and on serum.
C) A Wood's lamp is used to identify infections through immunofluorescent studies.
D) Patch tests are used to determine allergies.
Page Ref: 1627
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 21.5. Differentiate among common assessment procedures and tests used to examine tissue integrity.
MNL LO: Analyze the concept of tissue integrity and its application to nursing care.

5) A middle-aged adult client states to the nurse, "I do not want to have brown spots on my skin like my parents did as they got older." Which instruction by the nurse is appropriate?
A) Spend at least 15 minutes each day in the sun.
B) Increase the intake of calcium.
C) Increase the intake of dietary fat.
D) Avoid the sun or use a sunscreen to reduce skin damage.
Answer: D
Explanation: A) The nurse should not instruct the client to spend at least 15 minutes each day in the sun.
B) The intake of calcium will not affect the development of liver spots.
C) The intake of dietary fat will not affect the development of liver spots.
D) Small areas of hyperpigmentation, or liver spots, occur as an age-related skin change because of hyperplasia of melanocytes in sun-exposed areas.
Page Ref: 1638
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Client/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 21.8. Differentiate considerations related to the care of patients with alterations in tissue integrity throughout the lifespan.
MNL LO: Analyze the concept of tissue integrity and its application to nursing care.

6) The nurse is providing care to a client who is experiencing skin inflammation and pruritus. Which medications does the nurse anticipate will be prescribed for this client? **Select all that apply.**

A) Erythromycin
B) Bacitracin
C) Gentamycin
D) Desoximetasone
E) Desonide

Answer: D, E

Explanation: A) Erythromycin is an antibacterial that interferes with bacterial DNA and protein synthesis, causing cell death.

B) Bacitracin is an antibiotic that interferes with bacterial replication and synthesis and is used to treat infections.

C) Gentamycin is an antibiotic that interferes with bacterial replication and synthesis and is used to treat infections.

D) Desoximetasone is a topical corticosteroid that relieves inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses.

E) Desonide is a topical corticosteroid that relieves inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses.

Page Ref: 1635

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Client/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 21.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in tissue integrity.

MNL LO: Analyze the concept of tissue integrity and its application to nursing care.

7) A nurse educator is teaching a group of student nurses about newborn skin and factors that relate to this concept. Which statement will the educator include in the teaching session?
A) "The newborn's skin is about 40% to 60% thinner than an adult's skin at birth."
B) "The newborn's skin contains less water than an adult's and has tightly attached cells."
C) "The newborn's thicker skin decreases absorption of harmful chemical substances and topical medications."
D) "The newborn's skin has a greater percentage of underlying subcutaneous fat compared to adults."
Answer: A
Explanation: A) The newborn's skin is about 40% to 60% thinner than an adult's.
B) The newborn's skin contains more water than an adult's and has loosely attached cells.
C) The newborn's skin is more susceptible to absorption of harmful chemical substances and topical medications.
D) The newborn's skin has less subcutaneous fat compared to adults.
Page Ref: 1637
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Client/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 21.8. Differentiate considerations related to the care of patients with alterations in tissue integrity throughout the lifespan.
MNL LO: Analyze the concept of tissue integrity and its application to nursing care.

8) The nurse is working in a skilled nursing facility and is performing an assessment on an older adult client. The nurse notes that the client has hypopigmentation of the skin on both hands. The nurse should recognize that this condition is related to which age-related skin change?

A) Hyperplasia of melanocytes

B) Decreased perfusion of the dermis

C) Increased permeability of the epidermal layer

D) Hyperplasia of capillaries

Answer: A

Explanation: A) Hypopigmentation, also known as age spots, is a common finding on the back of the hands of an older adult. Hypopigmentation is caused by hyperplasia of melanocytes.

B) Hypopigmentation is not caused by decreased perfusion of the dermis.

C) Hypopigmentation is not caused by increased permeability of the epidermal layer.

D) Hypopigmentation is not caused by hyperplasia of capillaries.

Page Ref: 1638

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Client/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 21.8. Differentiate considerations related to the care of patients with alterations in tissue integrity throughout the lifespan.

MNL LO: Analyze the concept of tissue integrity and its application to nursing care.

9) Which finding should the nurse expect to assess in a client with impetigo?
A) An infection in the hair follicles
B) Loss of skin color in blotches or sections
C) An itchy rash with clusters of fluid-filled vesicles
D) A fungal infection in the skinfolds
Answer: C
Explanation: A) Folliculitis is an infection of hair follicles.
B) Vitiligo is a loss of skin color in blotches or sections that occur when the cells that produce melanin die or stop functioning.
C) Impetigo is a superficial skin infection common on the face, arms, and legs of children that presents as an itchy rash with clusters of fluid-filled vesicles that rupture easily. Ruptured vesicles develop a honey-colored crust over the lesions.
D) Candidiasis is a fungal infection commonly known as thrush and is found in skinfolds.
Page Ref: 1614
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.2. Differentiate alterations in tissue integrity.
MNL LO: Analyze the concept of tissue integrity and its application to nursing care.

10) A patient with an allergy to latex develops contact dermatitis following an examination during which the nurse wore latex gloves. Which best describes the associated pathophysiology?
A) An immune response that leads to issues with tissue integrity
B) Impaired tissue integrity that leads to an immune response
C) Impaired tissue integrity that leads to an infection
D) Decreased perfusion that leads to issues with tissue integrity
Answer: A
Explanation: A) Allergic reactions are an example of an immune response that leads to issues with tissue integrity.
B) Impaired tissue integrity, such as a cut, can lead to an immune response, but that is not the case in this scenario.
C) If left untreated or exposed to bacteria or other infectious agents, the dermatitis could lead to an infection, but there is no evidence of that in this scenario.
D) Decreased perfusion can lead to tissue damage or death, but not dermatitis.
Page Ref: 1627
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.3. Outline the relationship between tissue integrity and other concepts.
MNL LO: Analyze the concept of tissue integrity and its application to nursing care.

11) What impact might corticosteroids have on tissue integrity?
A) It may increase sensitivity to sunlight, leading to sunburns.
B) It may cause thinning of the skin, making skin more easily injured.
C) It may make skin appear shiny and lose its hair distribution.
D) It may cause the skin to become overly dry.
Answer: B
Explanation: A) Antibiotics, chemotherapy drugs, and some psychotherapeutic drugs increase sensitivity to sunlight and can predispose the individual to sunburns.
B) Some medications, such as corticosteroids, cause thinning of the skin, making it much more easily damaged.
C) Impaired peripheral arterial circulation in the lower extremities may produce skin that appears shiny and has lost its hair distribution.
D) Excessive cleansing can cause the skin to become overly dry.
Page Ref: 1627
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.4. Explain the promotion of healthy tissue.
MNL LO: Analyze the concept of tissue integrity and its application to nursing care.

12) The nurse is conducting a skin assessment of a client. Upon palpating skin temperature, the nurse notes the skin is warm and red. In which way should the nurse interpret this finding?
A) Decreased hydration
B) Decreased blood flow to the skin
C) Inflammation and elevated body temperature
D) Hypothyroidism
Answer: C
Explanation: A) Poor skin turgor is indicative of decreased hydration.
B) Decreased skin temperature is indicative of decreased blood flow to the skin.
C) Warm, red skin indicates inflammation and elevated body temperature.
D) Excessively dry skin is indicative of hypothyroidism.
Page Ref: 1612
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.5. Differentiate among common assessment procedures and tests used to examine tissue integrity.
MNL LO: Analyze the concept of tissue integrity and its application to nursing care.

Exemplar 21.A Burns

1) The nurse is providing care to a pediatric client who was admitted to the pediatric intensive care unit (PICU) with a partial-thickness thermal burn. When planning care for this client, which should the nurse consider regarding this type of burn?

A) Partial-thickness burns are deeper than superficial burns but still involve the epidermis only.

B) A superficial partial-thickness burn extends from the skin's surface into the papillary layer of the dermis.

C) A deep partial-thickness burn is often bright red and has a moist, glistening appearance with blister formation.

D) A superficial partial-thickness burn is less painful than a deep partial-thickness burn.

Answer: B

Explanation: A) Partial-thickness burns are deeper than superficial burns, extending from the epidermis into the dermis layer.

B) A superficial partial-thickness burn extends from the skin's surface into the papillary layer of the dermis.

C) A superficial partial-thickness burn is often bright red and has a moist, glistening appearance with blister formation.

D) A deep partial-thickness burn is less painful than a superficial partial-thickness burn because sensation is decreased at the site.

Page Ref: 1643

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 21.A. Analyze burns as they relate to tissue integrity. Identify the clinical manifestations of burns.

MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with burns.

2) The nurse working at a burn center is caring for a client with an electrical burn. According to the American Burn Association, how would this burn be classified?
A) Minor
B) Moderate
C) Major
D) Significant
Answer: C
Explanation: A) According to the American Burn Association, all electrical burns are not classified as minor.
B) According to the American Burn Association, all electrical burns are not classified as moderate.
C) According to the American Burn Association, all electrical burns are classified as major.
D) Significant is not a classification according to the American Burn Association.
Page Ref: 1646
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.A. Analyze burns as they relate to tissue integrity. Identify the clinical manifestations of burns.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with burns.

3) A client is evaluated after suffering severe burns to the torso and upper extremities. The nurse notes edema at the burned areas. Which statement best describes the underlying cause of this manifestation?
A) Decreased osmotic pressure in the burned tissue
B) Reduced microvascular permeability at the site of the burned area
C) Increased potassium in the intracellular compartment
D) Inability of the damaged capillaries to maintain fluids in the cell walls
Answer: D
Explanation: A) The osmotic pressure is increased, causing fluid accumulation.
B) There is an increase in microvascular permeability at the burn site.
C) Potassium ions leave the intracellular compartment, putting patients at risk for cardiac dysrhythmia due to hypokalemia.
D) Burn shock occurs during the first 24-36 hours after the injury. During this period, there is a shifting of fluid volume that is the direct result of lost cell wall integrity at the injury site and in the capillary bed.
Page Ref: 1647
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.A. Analyze burns as they relate to tissue integrity. Describe the pathophysiology, etiology, risk factors, and prevention of burns.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with burns.

4) Which data supports the nurse's concern that a client is at a high risk for a burn injury? **Select all that apply.**
A) Part-time employment at a convenience store
B) Diagnosis of hypertension
C) Age 71 years
D) Uses public transportation for grocery shopping
E) Currently smokes one pack of cigarettes per day
Answer: C, E
Explanation: A) Part-time employment does not increase the client's risk of experiencing a burn injury.
B) Hypertension does not increase the client's risk for experiencing a burn injury.
C) Older clients are more vulnerable to fire and burn injury because of decreased visual acuity, depth perception, sense of smell, and hearing, and because of impaired mobility. Alterations in cognition, such as dementia, are also risk factors.
D) Use of public transportation does not increase the client's risk of experiencing a burn injury.
E) Smoking is a risk factor.
Page Ref: 1641
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.A. Analyze burns as they relate to tissue integrity. Describe the pathophysiology, etiology, risk factors, and prevention of burns.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with burns.

5) An older adult client with severe burns over more than half of the body has an indwelling catheter. When evaluating the client's intake and output, which information should be taken into consideration?
A) The amount of urine will be elevated due to the amount of intravenous fluids administered during the initial phases of treatment.
B) The amount of urine will be reduced in the first 24 to 48 hours and will then increase.
C) The amount of urine will be reduced during the first 8 hours of the burn injury and will then increase as diuresis begins.
D) The amount of urine output will be greatest in the first 24 hours after the burn injury.
Answer: B
Explanation: A) The amount of urine is not elevated due to the amount of IV fluids during the initial phases of treatment.
B) The client will have an initial reduction in urinary output. Fluid is reduced in the initial phases as the body manages the insult caused by the injury and fluids are drawn into the interstitial spaces.
C) After the shock period passes, the client will enter a period of diuresis. Diuresis begins between 24 and 36 hours after the burn injury.
D) The amount of urine is not the greatest during the first 24 hours after a burn injury.
Page Ref: 1648, 1652
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 21.A. Analyze burns as they relate to tissue integrity. Apply the nursing process in providing culturally competent care to an individual with burns.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with burns.

6) A client who sustained burns to both lower extremities reports feeling frustrated by not being able to provide self-care. Which problem would be appropriate for the client at this time?
A) Problems with coping
B) Feelings of powerlessness
C) Anxiety
D) Low self-esteem
Answer: B
Explanation: A) There is not enough information to determine whether the client is or is not experiencing problems with coping.
B) The client is expressing frustration over not being able to provide self-care. The problem most appropriate for the client at this time would be feelings of powerlessness.
C) There is not enough information to determine whether the client is or is not experiencing anxiety.
D) There is not enough information to determine whether the client is or is not experiencing low self-esteem.
Page Ref: 1659
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 21.A. Analyze burns as they relate to tissue integrity. Apply the nursing process in providing culturally competent care to an individual with burns.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with burns.

7) The nurse is planning care for a client in the acute stage of a burn injury. Which aspects of care should the nurse identify as a priority? **Select all that apply.**
A) Nutrition
B) Psychosocial support
C) Pain management
D) Fluid resuscitation
E) Wound care
Answer: A, C, E
Explanation: A) Nursing care for the client during the acute stage of burn injuries will include nutritional therapy.
B) Psychosocial support will be needed once the client has stabilized.
C) Nursing care for the client during the acute stage of burn injuries will include pain management.
D) Fluid resuscitation occurs during the emergency phase of burn care.
E) Nursing care for the client during the acute stage of burn injuries will include wound care.
Page Ref: 1660
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise, and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 21.A. Analyze burns as they relate to tissue integrity. Apply the nursing process in providing culturally competent care to an individual with burns.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with burns.

8) The nurse is evaluating the adequacy of the burn-injured client's nutritional intake. Which laboratory value is the best indicator of nutritional status?
A) Creatine phosphokinase (CPK)
B) Blood urea nitrogen (BUN) levels
C) Hemoglobin
D) Albumin level
Answer: D
Explanation: A) Creatine phosphokinase is used to identify the presence of muscle injuries.
B) BUN levels are used to evaluate kidney function.
C) Hemoglobin levels will fluctuate with the stages of the burn injury, dependent on the fluid status.
D) Albumin level is used to indicate protein synthesis and nutritional status.
Page Ref: 1654
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 21.A. Describe the pathophysiology of burns. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with burns.

MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with burns.

9) The nurse is caring for a client who is to receive mechanical debridement of burn wounds. Which methods should the nurse anticipate using to complete this treatment? **Select all that apply.**
A) Homograft
B) Application of a topical agent to dissolve necrotic tissue
C) Irrigation of the burn wounds
D) Application of wet-to-dry gauze dressings
E) Hydrotherapy
Answer: C, D, E
Explanation: A) The application of a homograft is a type of dressing and not a type of debridement.
B) Applying a topical agent to dissolve necrotic tissue is an example of enzymatic debridement.
C) Mechanical debridement is done by irrigation.
D) Mechanical debridement is done by applying and removing wet-to-dry gauze dressings.
E) Mechanical debridement is done by hydrotherapy.
Page Ref: 1656
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 21.A. Analyze burns as they relate to tissue integrity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with burns.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with burns.

10) In which position should a client be placed after a graft procedure to the leg?
A) Place the client flat with the affected extremity abducted.
B) Elevate the head of bed 30 degrees
C) Maintain the head of bed flat
D) Elevate the affected extremity
Answer: D
Explanation: A) Leaving the head of bed flat and abducting the extremity will not increase healing or improve the client's long-range prognosis.
B) Elevating the head of bed will not increase healing or improve the client's long-range prognosis.
C) Leaving the head of the bed flat will not increase healing or improve the client's long-range prognosis.
D) Elevating the affected extremity will reduce edema and promote perfusion.
Page Ref: 1661
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise, and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 21.A. Analyze burns as they relate to tissue integrity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with burns.

MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with burns.

11) The nurse is planning to provide care to extended family members spanning three generations who are being treated for burn injuries after a fire. Which information should the nurse keep in mind when planning the care for this family?
A) The 38-year-old pregnant mother is more likely to require an allograft than the other members of the family.
B) The 82-year-old grandmother is more likely to have burns to a greater percentage of her total body surface area (TBSA) than younger family members.
C) The 14-year-old son is less likely to experience edema associated with his injuries than older members of the family.
D) The 6-year-old daughter is more likely to go into burn shock than the other members of the family.
Answer: B
Explanation: A) There is no evidence that a pregnant client will need an allograft before other family members.
B) The older adult population is more likely to suffer burns to a greater percentage of their TBSA than other age groups, largely because their skin is so much thinner and therefore more delicate than that of younger individuals.
C) There is no evidence that the 14-year-old client will have less edema than other family members.
D) There is no evidence that the 6-year-old client will go into burn shock before other family members.
Page Ref: 1658-1659
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 21.A. Analyze burns as they relate to tissue integrity. Differentiate considerations for care of patients with burns across the lifespan.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with burns.

12) An adult burn patient is brought into the intensive care unit (ICU) for treatment. Prior to sustaining the injury, the client was considered underweight. In which way will this impact the client's care?
A) The client will have lower fluid resuscitation calculations than patients of normal weight.
B) The client will be at greater risk for developing cardiac or renal insufficiencies.
C) The client will require more supportive care than clients who are normal weight.
D) The client will lose as much as 20% of her preburn weight during rehabilitation.
Answer: D
Explanation: A) Fluid resuscitation calculations are based on the time of injury, not body weight.
B) Clients with a past medical history of cardiac or renal problems are at an increased risk for cardiac and renal insufficiency regardless of weight.
C) Children and older adults require more supportive care than other client populations because of differences in their skin and healing, not because of their body weight.
D) During the acute and rehabilitative phases of the burn injury, the patient loses as much as 20% of preburn weight. This has significant implications for all patients, especially those who are underweight at the time of injury.
Page Ref: 1659
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 21.A. Analyze burns as they relate to tissue integrity. Apply the nursing process in providing culturally competent care to an individual with burns.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with burns.

13) An adult burn patient is receiving fluid resuscitation of warm, lactated Ringer's solution during the first 24 hours following injury. The client's hourly urine output is being monitored to determine whether the resuscitation is adequate. The most recent reading is 1.10 mL/kg/hr. In which way should the nurse interpret this output?
A) Slightly higher than the normal range.
B) Slightly lower than the normal range.
C) Within the normal range.
D) Extremely low.
Answer: A
Explanation: A) In adult patients with burn injuries who are receiving fluid resuscitation, urine production of 0.5-1 mL/kg/hr is considered normal. Therefore, the nurse would understand that this patient's output is slightly high.
B) This urine output is not lower than the normal range.
C) This urine output is not within the normal range.
D) This urine output is not extremely low.
Page Ref: 1653
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 21.A. Analyze burns as they relate to tissue integrity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with burns.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with burns.

14) A burn patient is currently in the acute stage. At which time did this stage begin, and when will it end?
A) It began with the onset of the burn injury and will end with fluid resuscitation.
B) It began with wound closure and will end when the patient's health is fully restored.
C) It began with the start of diuresis and will end with the closure of the burn wound.
D) It began with the onset of the burn injury and will end with the closure of the burn wound.
Answer: C
Explanation: A) The emergent/resuscitative stage begins with the onset of the burn injury and ends with successful fluid resuscitation.
B) The rehabilitative stage begins with wound closure and ends when the patient returns to the highest level of health restoration, which may take years.
C) The acute stage begins with the start of diuresis and ends with the closure of the burn wound, either by natural healing or by use of skin grafts.
D) The emergent/resuscitative stage begins with the onset of the burn injury.
Page Ref: 1652
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 21.A. Analyze burns as they relate to tissue integrity. Identify the clinical manifestations of burns.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with burns.

Exemplar 21.B Pressure Injuries

1) A client has a pressure injury on the medial malleolus. The client's skin is intact with purple discoloration and a blood-filled blister. When documenting this finding, which terminology is appropriate for the nurse to use?
A) Partial-thickness loss of dermis
B) Nonblanchable erythema
C) Suspected deep tissue injury
D) Full-thickness tissue loss
Answer: C
Explanation: A) Partial-thickness loss of dermis refers to a stage 2 pressure injury.
B) Nonblanchable erythema refers to a stage 1 pressure injury.
C) A suspected deep tissue injury manifests as intact skin with purple discoloration or a blood-filled blister.
D) Full-thickness tissue loss refers to stage 3, stage 4, and unstageable pressure injuries.
Page Ref: 1670
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 21.B. Analyze pressure injuries as they relate to tissue integrity. Identify the clinical manifestations of pressure injuries.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with pressure injuries.

2) The nurse is caring for a client with a stage 2 pressure injury on the coccyx who is at risk for additional pressure injuries. Which nursing intervention is appropriate when caring for this client?

A) Clean the pressure injury as needed.
B) Use hydrogen peroxide for chemical debridement of wound bed as needed.
C) Maintain the head of the client's bed at 30 degrees.
D) Avoid placing the client in the side-lying position.

Answer: D

Explanation: A) The nurse should clean the client's pressure injury at every dressing change, not as needed.

B) Hydrogen peroxide should never be used on the wound bed due to the tissue damage it promotes.

C) The nurse should maintain the head of the bed at the lowest degree of elevation consistent with the client's medical condition and other restrictions.

D) The nurse should avoid placing the client in the side-lying position because this position places increased pressure on the bony prominence of the greater trochanter.

Page Ref: 1672
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 21.B. Analyze pressure injuries as they relate to tissue integrity. Apply the nursing process in providing culturally competent care to an individual with pressure injuries.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with pressure injuries.

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3) An 84-year-old client with poor skin turgor has slipped down in the hospital bed. Which action by the nurse is appropriate to safely reposition this client to prevent further skin breakdown?
A) Using the bed sheet to slide the client up in bed
B) Placing the bed in reverse Trendelenburg position
C) Using the client's arms to pull the client up in bed
D) Lifting the client, using the client's legs and arms for assistance
Answer: D
Explanation: A) Sliding the client on a bed sheet also has the potential to cause shearing because the skin may adhere to the sheet.
B) Placing the bed in reverse Trendelenburg position will not facilitate appropriate positioning of the client in the bed.
C) Pulling the client up in bed may cause skin shearing.
D) The client is of advanced age and has poor skin turgor. Both of these factors put the client at increased risk for alterations in skin integrity, including damage due to shearing forces. To prevent shearing of the client's skin, the nurse should lift the client up in bed, using the client's legs and arms for assistance.
Page Ref: 1667
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 21.B. Analyze pressure injuries as they relate to tissue integrity. Describe the pathophysiology, etiology, risk factors, and prevention of pressure injuries.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with pressure injuries.

4) The nurse is concerned that a client is at risk for pressure injuries. Which assessment data supports the nurse's concern? **Select all that apply.**
A) Age 54
B) Body temperature within normal limits
C) Low serum albumin level
D) Continence of urine and stool
E) Prescribed bedrest
Answer: C, E
Explanation: A) Although advanced age increases the risk of pressure injuries, this client is only 54 years old.
B) Normal body temperature does not increase the client's risk for pressure injury development.
C) A low serum albumin level is evidence of inadequate nutrition.
D) Continence of urine and stool would reduce the risk of pressure injury development.
E) The client who is prescribed bedrest is at risk for immobility.
Page Ref: 1666
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.B. Analyze pressure injuries as they relate to tissue integrity. Describe the pathophysiology, etiology, risk factors, and prevention of pressure injuries.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with pressure injuries.

5) An older adult client is admitted to the medical-surgical unit for a hip fracture. During postoperative recovery, the nurse notices a stage 1 pressure injury forming on the client's sacrum. Which action by the nurse is appropriate to reduce the progression of this injury?
A) Maintain the head of the bed at a 30-degree angle, with the client positioned on the right or left side.
B) Apply a heat lamp to the area to increase circulation.
C) Apply a dry dressing to the pressure injury.
D) Maintain the head of the bed at a 45-degree angle.
Answer: A
Explanation: A) Keeping the head of the bed at an angle of 30 degrees or less decreases pressure on the sacrum.
B) Heat lamps are no longer used in the treatment of pressure injuries because they do not provide therapeutic benefit.
C) Dry dressings are not indicated with this stage of pressure injury.
D) An angle of 45 degrees would be too severe and could exacerbate pressure injury formation on the sacrum.
Page Ref: 1667
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 21.B. Analyze pressure injuries as they relate to tissue integrity. Describe the pathophysiology, etiology, risk factors, and prevention of pressure injuries.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with pressure injuries.

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6) A client has a documented stage 3 pressure injury on the right hip. Which problem is most appropriate for this client?
A) Potential for impaired skin integrity
B) Risk of infection
C) Impaired skin integrity
D) Potential for compromised dignity
Answer: C
Explanation: A) Because a stage 3 pressure injury is present, potential for impaired skin integrity would not apply.
B) There is no evidence that the client is at risk for infection at this time.
C) Because a stage 3 pressure injury is present, impaired skin integrity would apply.
D) There is no evidence that the client has the potential for compromised dignity.
Page Ref: 1674
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 21.B. Analyze pressure injuries as they relate to tissue integrity. Apply the nursing process in providing culturally competent care to an individual with pressure injuries.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with pressure injuries.

7) When planning care for a client at risk for developing pressure injuries, which intervention(s) should be included? **Select all that apply.**
A) Initiate a frequent toileting schedule.
B) Raise the client's heels off the bed.
C) Turn the client every 4 hours.
D) Use inflatable doughnut-style devices to reduce pressure on the sacrum.
E) Massage pressure areas with lotion every 4 hours.
Answer: A, B
Explanation: A) Urine and feces are destructive to skin. A frequent toileting schedule will reduce periods of incontinence and the potential for skin breakdown.
B) The client's heels should be raised off the bed to remove pressure on this area of the body.
C) The client should be turned at least every 2 hours.
D) Inflatable doughnut-style devices are contraindicated, because they increase pressure and reduce perfusion to affected areas.
E) Massaging pressure areas can cause friction and damage to problem skin areas.
Page Ref: 1667-1668
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 21.B. Analyze pressure injuries as they relate to tissue integrity. Describe the pathophysiology, etiology, risk factors, and prevention of pressure injuries.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with pressure injuries.

8) The nurse is caring for a client who failed to meet the outcome of healing of a stage 2 pressure injury over the coccyx. Which should the nurse identify as a likely contributing factor?

A) The rubber doughnut pressure relief device was not delivered by central supply.

B) The client's serum albumin increased over the last month.

C) A right side-back-left side-back turning schedule was used.

D) Nurses did not document disinfection of the wound with alcohol at each dressing change.

Answer: C

Explanation: A) A rubber doughnut-style device should not be used, so the fact that it was not delivered did not contribute to failure to meet the outcome.

B) An increase in serum albumin is a good finding and would increase, not decrease, wound healing.

C) Of the options listed, the only one that would result in poor healing is the right side-back-left side-back turning schedule. This schedule places the client on the back 50% of the time, which is where the ulcer is located. There are six possible body positions when preventing or treating a pressure ulcer, and these positions should be used equally.

D) Alcohol interrupts healing, so it is good that nurses did not use alcohol to disinfect the wound.

Page Ref: 1685

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 21.B. Analyze pressure injuries as they relate to tissue integrity. Apply the nursing process in providing culturally competent care to an individual with pressure injuries.

MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with pressure injuries.

9) A client requests a small inflated doughnut-style device to sit on to relieve pressure. Which response by the nurse is most appropriate?

A) "I will need to get an order from the physician."

B) "Using the doughnut can cause skin breakdown."

C) "You will need to wait until discharge, then use the doughnut at home."

D) "I will obtain the device for you."

Answer: B

Explanation: A) Use of a doughnut-style device should be avoided whether at the hospital or at home.

B) Use of a doughnut-style device applies pressure and results in tissue anoxia. The client may indeed feel that pressure is lessened with use of the device, but this is due to the loss of sensation.

C) Use of a doughnut-style device should be avoided whether at the hospital or at home.

D) Use of a doughnut-style device applies pressure and results in tissue anoxia. The client may indeed feel that pressure is lessened with use of the device, but this is due to the loss of sensation.

Page Ref: 1668

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 21.B. Analyze pressure injuries as they relate to tissue integrity. Describe the pathophysiology, etiology, risk factors, and prevention of pressure injuries.

MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with pressure injuries.

10) A client's spouse reports the presence of a reddened area on the client's coccyx and wants to massage the area. Which response by the nurse is appropriate?
A) "I will need to obtain an order from the healthcare provider to perform a massage."
B) "Massaging the area twice daily will help restore circulation and should be incorporated into the plan of care."
C) "I will record these findings in the medical record."
D) "Massage may actually cause more harm to a potentially compromised area of skin."
Answer: D
Explanation: A) Even when appropriate and therapeutic for a client, massages do not require a healthcare provider's order.
B) Evidence suggests that massage over bony prominences like the coccyx can cause or worsen deep tissue trauma in patients at risk for a pressure injury.
C) The nurse needs to make a response about the area and not about documenting the finding.
D) Redness may indicate the presence of a stage 1 pressure injury. Evidence suggests that massage over bony prominences like the coccyx can cause or worsen deep tissue trauma in patients at risk for a pressure injury.
Page Ref: 1675
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise, and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 21.B. Analyze pressure injuries as they relate to tissue integrity. Describe the pathophysiology, etiology, risk factors, and prevention of pressure injuries.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with pressure injuries.

11) The nurse is conducting a training session with new staff members at a nursing home. One of the staff members asks why the facility's older adult clients are at elevated risk for pressure injuries. Which response is best?
A) "As people age, their epidermis becomes more elastic. This increased elasticity makes older adults' skin more susceptible to damage."
B) "As compared to younger clients, older adults have higher average body temperatures, and excess body heat is a risk factor for pressure injuries."
C) "Due to increased oil production, the skin of older adults tends to be moister than that of younger clients. Increased moistness increases the risk for impaired skin integrity."
D) "Age-related changes in the veins and arteries put older adults at risk for diminished blood flow, which can contribute to impaired skin integrity."
Answer: D
Explanation: A) Older clients have less elasticity of the skin.
B) Although excess body heat is a risk factor for pressure injuries, older adults tend to have lower average body temperatures than younger clients.
C) Increased dryness due to a decrease in the amount of oil produced by the sebaceous glands increases the risk for impaired skin integrity in older adults.
D) Older adults are at increased risk for pressure injuries because of diminished venous and arterial flow due to aging vascular walls.
Page Ref: 1666
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 21.B. Analyze pressure injuries as they relate to tissue integrity. Describe the pathophysiology, etiology, risk factors, and prevention of pressure injuries.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with pressure injuries.

12) What stage of pressure injury presents as a shallow open ulcer with a viable, moist wound bed that is red or pink?
A) Stage 1
B) Stage 2
C) Stage 3
D) Stage 4
Answer: B
Explanation: A) A stage 1 pressure injury is characterized by nonblanchable intact skin.
B) A stage 2 pressure injury is characterized by partial-thickness skin loss involving the dermis. It presents as a shallow open ulcer with a viable, moist wound bed that is red or pink.
C) A stage 2 pressure injury is characterized by partial-thickness skin loss involving the dermis. It presents as a shallow open ulcer with a viable, moist wound bed that is red or pink. Granulation tissue is present in a stage 3 pressure injury.
D) Slough and eschar are present in a stage 4 pressure injury.
Page Ref: 1669
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.B. Analyze pressure injuries as they relate to tissue integrity. Identify the clinical manifestations of pressure injuries.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with pressure injuries.

13) Which term will the nurse use to describe softening of the skin as a result of prolonged wetting or soaking?
A) Maceration
B) Debridement
C) Excoriation
D) Shearing
Answer: A
Explanation: A) Maceration involves softening of the skin due to prolonged wetting or soaking.
B) Debridement is the removal of necrotic material from a wound.
C) Excoriation is loss of the superficial layers of the skin.
D) Shearing occurs when one layer of tissue slides over another.
Page Ref: 1666
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.B. Analyze pressure injuries as they relate to tissue integrity. Describe the pathophysiology, etiology, risk factors, and prevention of pressure injuries.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with pressure injuries.

14) Which client would be the most appropriate candidate for autolytic debridement?
A) A 47-year-old client with a stage 2 pressure injury
B) A 68-year-old client with a suspected deep tissue injury
C) A 71-year-old client with a stage 1 pressure injury
D) A 59-year-old client with a stage 3 pressure injury
Answer: D
Explanation: A) Debridement is for a pressure injury greater than stage 2.
B) Debridement is for a pressure injury greater than stage 2 and not for a suspected deep tissue injury.
C) Debridement is for a pressure injury greater than a stage 1.
D) Debridement, regardless of type, is typically reserved for pressure injuries with full-thickness tissue loss. This includes stage 3 pressure injuries, stage 4 pressure injuries, and (in some cases) unstageable pressure injuries.
Page Ref: 1671
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 21.B.5. Analyze pressure injuries as they relate to tissue integrity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with pressure injuries.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with pressure injuries.

Exemplar 21.C Wound Healing

1) A client has a laceration that was closed with tissue adhesive. By what process will this wound heal?
A) Tertiary intention
B) Secondary intention
C) Delayed primary intention
D) Primary intention
Answer: D
Explanation: A) With tertiary intention healing, also called delayed primary intention healing, wounds are left open for 3 to 5 days to allow edema or infection to resolve before being closed by sutures, staples, or adhesive skin closures.
B) Secondary intention healing involves wounds that cannot be approximated and that must "heal in." These wounds are at higher risk for infection, take longer to heal, and are more prone to scarring.
C) Delayed primary intention is not a process of wound healing.
D) In primary intention wound healing, the edges of the wounds are approximated and held together with sutures, bandages, or tissue adhesive. Scarring is minimal with these wounds.
Page Ref: 1679
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 21.C. Analyze wound healing as it relates to tissue integrity. Describe the phases of wound healing, risk factors for complications, and health promotion for good wound healing.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with wound healing.

2) A client recovering from abdominal surgery tells the nurse that "something popped" in the abdominal incision. Upon inspection, the nurse finds that evisceration has occurred. Which actions by the nurse are appropriate? **Select all that apply.**
A) Notify the client's surgeon.
B) Pack the client's wound with nonadherent gauze.
C) Turn the client onto his abdomen.
D) Position the client in bed with his knees bent.
E) Cover the incision with a large, saline-soaked dressing.
Answer: A, D, E
Explanation: A) The nurse should notify the surgeon.
B) Nothing should be packed into this wound.
C) The client should not be turned onto the abdomen.
D) The nurse should position the client with the knees bent.
E) The nurse should cover the area with a large, saline-soaked dressing to keep the viscera moist.
Page Ref: 1681
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN 2021 Domains and Competencies 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 21.C. Analyze wound healing as it relates to tissue integrity. Describe the phases of wound healing, risk factors for complications, and health promotion for good wound healing.

MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with wound healing.

3) An older adult client diagnosed with chronic obstructive pulmonary disease (COPD) is scheduled for a total knee replacement. Which intervention should the nurse include in this client's plan of care to address the risk of an alteration in tissue integrity?

A) Monitor urine output.

B) Assess postoperative wound healing.

C) Restrict protein intake.

D) Expect purulent drainage.

Answer: B

Explanation: A) The client may or may not need to have urine output monitored.

B) Chronic lung disease reduces the amount of oxygen delivered to the tissues, which could delay wound healing. Furthermore, regardless of their chronic disease status, older adults often experience slowed healing as a result of normal cellular and molecular changes. Thus, it is critical that the nurse regularly assess the postoperative wound for healing.

C) Postoperative clients need adequate protein for wound healing, so protein intake should not be restricted.

D) Purulent drainage is a sign of infection and would not be expected.

Page Ref: 1684

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 21.C. Analyze wound healing as it relates to tissue integrity. Differentiate considerations for care of patients with wounds across the lifespan.

MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with wound healing.

4) A client is admitted to the hospital with a gunshot wound to the leg. Which problem is a priority?
A) Risk for low self-esteem
B) Potential for infection
C) Anxiety
D) Difficulty coping
Answer: B
Explanation: A) There is no evidence the client is at risk for low self-esteem.
B) A client with a gunshot wound is at risk for infection because the wound is severe and caused by trauma.
C) There is no evidence that the client will develop anxiety.
D) There is no evidence that the client will have difficulty coping.
Page Ref: 1685
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 21.C. Analyze wound healing as it relates to tissue integrity. Apply the nursing process in providing culturally competent care to an individual with a wound.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with wound healing.

5) The nurse is planning care for a client with a surgical wound. Which goal related to the surgical wound is most appropriate for this client?

A) The client will discharge to home as soon as possible.
B) The client will resume independent activities of daily living (ADLs).
C) The client will increase ambulation.
D) The client will regain intact skin.

Answer: D

Explanation: A) For some patients, discharge to home may not be an appropriate goal.
B) For some patients, resuming independent ADL may not be an appropriate goal.
C) For some patients, increasing ambulation may not be an appropriate goal.
D) This client has impaired skin integrity because of a surgical wound. An appropriate goal of care would be for the client to experience wound healing to achieve intact skin.

Page Ref: 1685

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 21.C. Analyze wound healing as it relates to tissue integrity. Apply the nursing process in providing culturally competent care to an individual with a wound.

MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with wound healing.

6) The nurse is assessing a client with a surgical wound. Which finding indicates that care has been effective for this client?
A) The client's temperature is 100°F.
B) The client performs wound care independently.
C) There is only a scant amount of purulent drainage on the dressing.
D) A small area of erythema and edema is present.
Answer: B
Explanation: A) An elevated temperature could mean the wound is infected.
B) Evidence of effective care for a client with a surgical wound includes the client performing wound care independently.
C) Purulent drainage could mean the wound is infected.
D) Erythema and edema could indicate the wound is inflamed or infected.
Page Ref: 1685
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 21.C. Analyze wound healing as it relates to tissue integrity. Apply the nursing process in providing culturally competent care to an individual with a wound.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with wound healing.

7) An older adult client with poor nutritional intake is demonstrating signs of poor wound healing. Which intervention best addresses the client's nutritional needs?
A) Assist with deep-breathing exercises.
B) Medicate for pain prior to dressing changes.
C) Request a dietary consult.
D) Encourage ambulation.
Answer: C
Explanation: A) Deep-breathing exercises may or may not help the client at this time.
B) Medicating for pain prior to dressing changes is not going to help with wound healing.
C) The nurse should consult with a dietitian to identify ways to improve the client's intake to support wound healing.
D) Ambulation may or may not help the client at this time.
Page Ref: 1685
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 21.C. Analyze wound healing as it relates to tissue integrity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a wound.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with wound healing.

8) A client has a wound on the left lateral aspect of the thigh. Which action by the nurse would best promote wound healing for this client?
A) Positioning the client to keep weight off the wound
B) Positioning the client with weight directly on the wound
C) Restricting fluids
D) Enforcing strict bedrest
Answer: A
Explanation: A) To promote wound healing, the client should be positioned to keep pressure off the wound.
B) To promote wound healing, the client should be positioned to keep pressure off the wound, not directly on it.
C) Fluid restriction does not encourage wound healing.
D) The client should be assisted in early ambulation, and strict bedrest should not be enforced.
Page Ref: 1685
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 21.C. Analyze wound healing as it relates to tissue integrity. Apply the nursing process in providing culturally competent care to an individual with a wound.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with wound healing.

9) A home care nurse is caring for a client who is recovering from recent surgical debridement that produced large amounts of exudate. Three days after the debridement, the client's surgical wound was closed with staples that are aiding in healing. Given this information, which term should the nurse use when documenting this client's care?
A) Primary intention healing
B) Secondary intention healing
C) Tertiary intention healing
D) Quaternary intention healing
Answer: C
Explanation: A) Primary intention healing occurs where tissue surfaces have been approximated (closed) and there is minimal or no tissue loss.
B) A wound that is extensive and involves considerable tissue loss and in which the edges cannot or should not be approximated heals by secondary intention healing.
C) Wounds that are left open for 3-5 days to allow edema or infection to resolve or to permit exudate to drain and then are closed with sutures, staples, or adhesive skin closures undergo tertiary intention healing.
D) Quaternary intention healing does not exist.
Page Ref: 1679
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 21.C. Analyze wound healing as it relates to tissue integrity. Describe the phases of wound healing, risk factors for complications, and health promotion for good wound healing.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with wound healing.

10) The nurse working in the intensive care unit (ICU) is caring for a client who is 10 days postoperative after open abdominal surgery. The client has a well-approximated midline surgical incision that has numerous staples, and the nurse notes a "healing ridge" is present. Based on this information, the incision is currently in which phase of the healing process?

A) Inflammatory phase
B) Proliferative phase
C) Maturation phase
D) Synthesis phase

Answer: B

Explanation: A) The wound is red and edematous in the inflammatory phase.
B) The proliferative phase, which is the second phase in the healing process, extends from day 3 or 4 to about day 21 postinjury. If the wound is sutured, a raised "healing ridge" appears under the intact suture line.
C) A scar is present during the maturation phase. The proliferative phase, which is the second phase in the healing process, extends from day 3 or 4 to about day 21 postinjury. If the wound is sutured, a raised "healing ridge" appears under the intact suture line. There is no synthesis phase in the healing process, and the other choices are incorrect.
D) Synthesis is not a phase in wound healing.

Page Ref: 1680
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.C. Analyze wound healing as it relates to tissue integrity. Describe the phases of wound healing, risk factors for complications, and health promotion for good wound healing.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with wound healing.

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11) Which statement about wound care across the lifespan is correct?
A) "When applying transparent dressings on older adult clients, do not hold the skin taut, because doing so can cause damage."
B) "In young children, staph bacteria and fungi are the most common causes of infection in minor wounds."
C) "Pressure injuries and contact irritation are rare among newborns and infants in NICUs."
D) "As compared to younger clients, older adults have a heightened inflammatory response, which can contribute to delayed wound healing."
Answer: B
Explanation: A) The skin of older adult clients should be held taut when applying transparent dressings.
B) The two major infectious agents affecting the skin of children are *Staphylococcus* and fungi.
C) Pressure injuries and contact irritation are common among hospitalized newborns and infants.
D) Older adults have a delayed inflammatory response as compared to younger clients.
Page Ref: 1683
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.C. Analyze wound healing as it relates to tissue integrity. Differentiate considerations for care of patients with wounds across the lifespan.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with wound healing.

12) Hemostasis and phagocytosis are characteristic of which stage of the wound healing process?
A) Inflammatory phase
B) Proliferative phase
C) Granulation phase
D) Maturation phase
Answer: A
Explanation: A) The inflammatory phase of wound healing is initiated immediately after injury and lasts 3-6 days. Two major processes occur during this phase: hemostasis and phagocytosis.
B) Hemostasis and phagocytosis do not occur during the proliferative phase.
C) There is not a granulation phase of wound healing.
D) A scar is formed during the maturation phase.
Page Ref: 1679
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.C. Analyze wound healing as it relates to tissue integrity. Describe the phases of wound healing, risk factors for complications, and health promotion for good wound healing.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with wound healing.

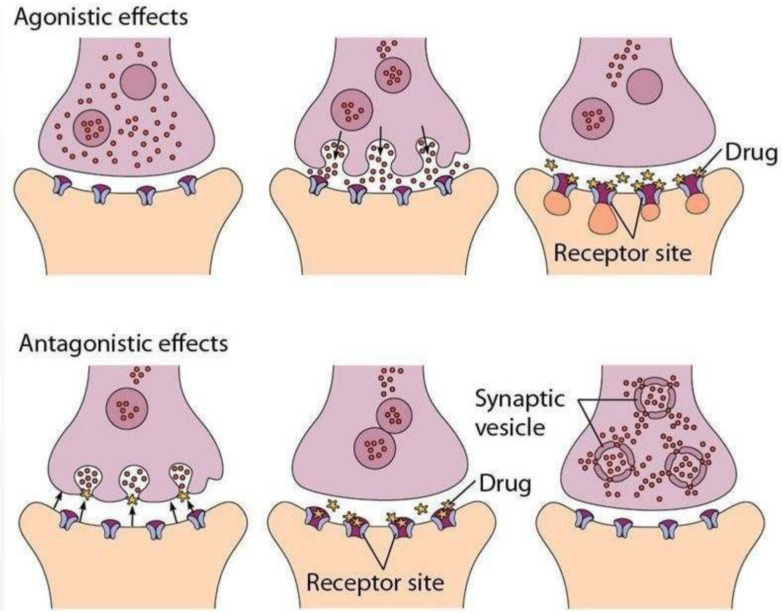
13) Which finding suggests that a wound is infected with pyogenic bacteria?
A) Sanguineous exudate
B) Serous exudate
C) Serosanguineous exudate
D) Purulent exudate
Answer: D
Explanation: A) Sanguineous exudate consists of large amounts of red blood cells.
B) Serous exudate is clear or straw colored and has few cells.
C) Serosanguineous exudate consists of both clear and blood-tinged drainage.
D) Purulent exudate is more commonly called pus, and it is created by microorganisms known as pyogenic bacteria.
Page Ref: 1681
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 21.C. Analyze wound healing as it relates to tissue integrity. Identify the clinical manifestations of wounds.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with wound healing.

14) Which medication may be discontinued in a client who is experiencing delayed wound healing?
A) Oral prednisone
B) Topical antibiotics
C) Topical growth factors
D) Oral antibiotics
Answer: A
Explanation: A) Oral prednisone is a steroid. Steroids are known to interfere with healing, so it is likely that use of these drugs may be discontinued.
B) Topical antibiotics may be appropriate for clients with delayed wound healing, because they can help prevent infection.
C) Topical growth factors may be applied to a wound in an attempt to "jump start" the healing process.
D) Oral antibiotics may be appropriate for clients with delayed wound healing, because they can help prevent infection.
Page Ref: 1680
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 21.C. Analyze wound healing as it relates to tissue integrity. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a wound.
MNL LO: Demonstrate understanding of the concept of tissue impairment in the care of a patient with wound healing.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 22 Addiction

The Concept of Addiction

1) The nurse at an outpatient addiction clinic uses the following diagram as a teaching tool. In which way should this diagram be interpreted?



A) Most abused substances either imitate or block the action of neurotransmitters.
B) In order to be addictive, a substance must cause the release of excess neurotransmitters.
C) Substances that exert antagonistic effects can be used to counteract the addictive tendencies of substances that exert agonistic effects.
D) People with addictive personalities process neurotransmitters differently than people who are less prone to addiction.
Answer: A
Explanation: A) Most abused substances either mimic or block neurotransmitters at critical receptor sites.
B) These drugs exert agonistic effects if they boost neurotransmitter synthesis, increase neurotransmitter release, or activate receptors that normally respond to neurotransmitters.
C) Abused substances exert antagonistic effects if they interfere with neurotransmitter release, occupy receptor sites that are normally sensitive to neurotransmitters, or cause leakage of neurotransmitters from synaptic vesicles. Both drugs with agonistic effects and those with antagonistic effects can be addictive, and administering one class of drug will not counteract the addictive tendencies of the other class.
D) Researchers have not identified an addictive personality type.
Page Ref: 1694
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 22.1. Summarize the processes involved in addiction.
MNL LO: Analyze the concept of addiction and its application to nursing care.

2) A public health nurse is presenting a teaching session about alcohol use to a group of college seniors. During the session, one of the students admits to frequent alcohol use. Which action should the nurse take?
A) Initiate a community assessment of the campus
B) Contact the campus nurse and refer the student for services
C) Notify campus security that the student may be driving while intoxicated
D) Complete a crisis assessment with the student
Answer: D
Explanation: A) A community assessment is not necessary at this time because the issue appears to be limited to this particular student.
B) Contacting the campus nurse is not advised without the student's permission.
C) There is no evidence that the student is driving while intoxicated.
D) The student should be assessed to determine the extent of crisis he or she is facing as the result of frequent alcohol use. This crisis assessment will allow the nurse to determine the appropriate course of action.
Page Ref: 1702
Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 22.5. Differentiate common assessment procedures and tests used to examine individuals suspected of abusing a substance.
MNL LO: Analyze the concept of addiction and its application to nursing care.

3) The nurse educator is teaching a group of students about theories of addiction. Which student statements indicate proper understanding of these theories? **Select all that apply.**
A) "Addiction occurs because of a lack of emotional attachment."
B) "There is a biological factor involved in the development of addiction."
C) "There are social factors that contribute to the development of addiction."
D) "There is a moral factor involved in the development of addiction."
E) "There are psychologic elements involved in the development of addiction."
Answer: B, C, E
Explanation: A) Viewing addiction as only a behavioral or emotional problem oversimplifies a complex issue.
B) E. Morton Jellinek first identified biological factors in his disease model of alcoholism.
C) Sociocultural factors often influence individuals' decisions as to when, what, and how they use substances.
D) The view of addiction as a moral disease is nontherapeutic.
E) Research indicates a high correlation among substance use and childhood and adolescent trauma, such as emotional, physical, or sexual abuse. Substance abuse often co-occurs with psychiatric disorders such as anxiety and depression, as some individuals use a substance as a coping strategy and, over time, develop an addiction.
Page Ref: 1694-1695
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 22.1. Summarize the processes involved in addiction.
MNL LO: Analyze the concept of addiction and its application to nursing care.

4) The nurse observes the family dynamics of an adolescent client who has an addiction problem. Which behavior indicates to the nurse that the family is demonstrating codependency behavior?
A) The family is intolerant of any frustration on the part of the client.
B) The family engages in actions that enable the client's self-destructive behavior.
C) The family is argumentative about seemingly insignificant issues.
D) The family exhibits high levels of impatience.
Answer: B
Explanation: A) Although intolerance of frustration may also be present in this family, they are generally not related to the cycle of codependence and addiction.
B) Codependence is a cluster of maladaptive behaviors exhibited by the significant others of a substance-abusing individual that serve to protect and perpetuate the abuse. Codependence frequently involves enabling behavior, which is any action an individual takes that either consciously or unconsciously facilitates substance dependence.
C) Although argumentative behaviors may also be present in this family, they are generally not related to the cycle of codependence and addiction.
D) Although impatience may also be present in this family, they are generally not related to the cycle of codependence and addiction.
Page Ref: 1697
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 22.3. Outline the relationship between addiction and other concepts.
MNL LO: Analyze the concept of addiction and its application to nursing care.

5) The nurse is conducting a crisis assessment for a client who admits to cocaine use. Which questions are appropriate for the nurse to ask the client during this process? **Select all that apply.**
A) "Do you have access to any recreational centers?"
B) "What is the most significant problem affecting your life right now?"
C) "How long has this been a problem?"
D) "What are the living conditions in your neighborhood?"
E) "What other stresses are you dealing with?"
Answer: B, C, E
Explanation: A) Questions about recreational centers are more appropriate for a community crisis assessment than for an individual crisis assessment.
B) When conducting a crisis assessment for a client who admits to using a substance that is associated with addiction, the nurse should ask about the most significant problem in the client's life right now.
C) When conducting a crisis assessment for a client who admits to using a substance that is associated with addiction, the nurse should ask how long this problem has been occurring.
D) Questions about neighborhood living conditions are more appropriate for a community crisis assessment than for an individual crisis assessment.
E) When conducting a crisis assessment for a client who admits to using a substance that is associated with addiction, the nurse should ask what other stresses may be affecting the client.
Page Ref: 1702
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 22.5. Differentiate common assessment procedures and tests used to examine individuals suspected of abusing a substance.
MNL LO: Analyze the concept of addiction and its application to nursing care.

6) A client is admitted to the emergency department with signs of drug use. The client reports ingesting Percocet and is currently experiencing respiratory depression. Based on this information, which prescription should the nurse anticipate for this client?
A) Diazepam
B) Haldol
C) Vitamin B_{12}
D) Naloxone
Answer: D
Explanation: A) Diazepam would be prescribed to manage the symptoms of substance withdrawal.
B) Haldol would be administered to manage an overdose of phencyclidine (PCP).
C) Vitamin B_{12} would be used to manage the neurologic symptoms that might accompany a nitrate overdose.
D) Percocet (oxycodone and acetaminophen) is an opioid narcotic. Thus, the nurse should anticipate administration of naloxone (Narcan), because this medication is used in the treatment of narcotic overdose.
Page Ref: 1709
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 22.7. Summarize collaborative therapies used by interprofessional teams for patients with substance use disorders.
MNL LO: Analyze the concept of addiction and its application to nursing care.

7) The nurse who runs an addiction treatment group at an inner-city clinic has noticed that many of the group's participants struggle with the stigma attached to their condition. Which statement should the nurse make to help participants overcome this stigma?
A) "Relapse is a common feature of substance abuse."
B) "Heredity and complex environmental influences predispose some people to substance dependence."
C) "People who have an addiction problem cannot be held accountable for their actions."
D) "Alcoholics Anonymous and Narcotics Anonymous are both accepted treatment approaches."
Answer: B
Explanation: A) Although many clients with a history of substance abuse do relapse, this information would not help overcome the stigma of addiction.
B) Many clients with addiction struggle with the stigma associated with their condition; for instance, they may feel that addiction is a form of moral failure or a result of personal weakness. Reassuring clients that addiction is rooted in a combination of heredity and environmental factors may help them overcome some of these false beliefs and move toward recovery.
C) Nurses should strive to hold clients with addiction accountable for their actions; absolving them of responsibility only serves to enable their substance abuse.
D) Although many clients with a history of substance abuse do relapse, information regarding Alcoholics Anonymous or Narcotics Anonymous would not be helpful.
Page Ref: 1694-1695
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 22.1. Summarize the processes involved in addiction.
MNL LO: Analyze the concept of addiction and its application to nursing care.

8) An employee health nurse is providing care to a worker who was injured on the job. The client has a history of drug addiction and is currently enrolled in a 12-step recovery program. In order to determine whether the employee was impaired at the time of the accident, which diagnostic tool should the nurse use?
A) Liver enzymes
B) Stool guaiac
C) Toxicology testing
D) Hair testing
Answer: C
Explanation: A) Liver enzymes detect liver damage but are not specific to damage from substance abuse.
B) A stool guaiac tests for blood.
C) Toxicology testing will determine whether the employee had drugs in the system during the shift in which the injury occurred.
D) Hair testing can detect substance use for up to 90 days and is not an accurate tool to determine whether the employee was impaired at the time of the injury.
Page Ref: 1702
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 22.5. Differentiate common assessment procedures and tests used to examine individuals suspected of abusing a substance.
MNL LO: Analyze the concept of addiction and its application to nursing care.

9) A client with an alcohol addiction is able to hide the addiction from family and friends. Based on this information, which independent nursing intervention is appropriate for this client?
A) Assertiveness training
B) Milieu therapy
C) Family therapy
D) Communication training
Answer: D
Explanation: A) Cultural norms must be carefully considered prior to implementing assertiveness training.
B) Milieu therapy involves collaboration with therapists.
C) Family therapy involves collaboration with therapists.
D) Many clients and families with addiction need training in communication skills. Verbal and nonverbal communication training is a vital independent nursing action.
Page Ref: 1703
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 22.6. Analyze independent interventions nurses can implement for patients with substance use disorders.

MNL LO: Analyze the concept of addiction and its application to nursing care.

10) A client with a history of alcohol abuse is being discharged to a treatment facility. Which prescription does the nurse anticipate for this client?
A) Disulfiram
B) Naloxone
C) Bupropion hydrochloride
D) Varenicline
Answer: A
Explanation: A) Disulfiram (Antabuse) is an abstinence medication that would cause the client to become immediately and violently ill when consuming alcohol.
B) Naloxone is administered to clients who overdose on opiates.
C) Bupropion hydrochloride assists with smoking cessation.
D) Varenicline assists with smoking cessation.
Page Ref: 1708
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 22.7. Summarize collaborative therapies used by interprofessional teams for patients with substance use disorders.
MNL LO: Analyze the concept of addiction and its application to nursing care.

11) A community health nurse is providing teaching to the faculty of a local high school about preventing, recognizing, and treating substance use and addiction in teenagers. Which statement indicates to the nurse that further teaching is necessary?
A) "The earlier a teenager begins using substances, the more likely it is that the teenager will develop an addiction problem."
B) "Teenagers whose parents suffer from addiction are at greater risk of addiction themselves."
C) "The brain stops developing during the teenage years, so any substance-related brain changes that occur during this period will likely affect a person for the rest of their life."
D) "Group therapy can be beneficial for teenagers with addiction, but it comes with a risk of unintended adverse effects."
Answer: C
Explanation: A) Teenagers who start using substances early are more likely to become addicted.
B) Teenagers who have parents who struggle with addiction are more likely to become addicted themselves.
C) The human brain continues developing well into a person's mid-20s. The relative immaturity of the adolescent brain helps explain why teenagers are more likely than adults to engage in thrill-seeking, high-risk behaviors such as substance use.
D) Group therapy can be a useful treatment method for teenage clients, but it must be led by a trained facilitator to ensure that group members don't steer conversation toward talk that glorifies or extols substance use.
Page Ref: 1710
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 22.8. Differentiate considerations related to the assessment and care of patients throughout the lifespan who abuse substances.
MNL LO: Analyze the concept of addiction and its application to nursing care.

12) The adult daughter is concerned after learning that an older parent has been using substances and no one was able to detect the use. Which response should the nurse avoid in response?
A) "Substance abuse and addiction are almost unheard of among older adults, so few providers would consider the possibility of these diagnoses when working with clients like your father."
B) "Older adults often choose not to tell their providers about substance use because they either don't recognize they have a problem or don't feel they need treatment."
C) "Diagnosis of substance abuse can be difficult in older clients because their symptoms sometimes mimic those of other disorders."
D) "There is currently little research data on substance abuse in the older adult population, which means many providers are unaware of the actual extent of this problem."
Answer: A
Explanation: A) Substance abuse in older adults is believed to be underestimated, underidentified, underdiagnosed, and undertreated. Until relatively recently, alcohol and prescription drug misuse was not discussed in either the substance abuse or the gerontologic literature.
B) Many older adults do not seek treatment for substance abuse because they do not feel they need it.
C) Diagnosis is often difficult because symptoms of substance abuse in older individuals sometimes mimic symptoms of other medical and behavioral disorders.
D) Insufficient knowledge, limited research data, and hurried office visits are cited as reasons why healthcare providers often overlook substance abuse and misuse in this population.
Page Ref: 1710
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 22.8. Differentiate considerations related to the assessment and care of patients throughout the lifespan who abuse substances.
MNL LO: Analyze the concept of addiction and its application to nursing care.

13) Which term refers to a physiologic need for a substance that the client cannot control and that results in withdrawal symptoms if the substance is withheld?
A) Tolerance
B) Dependence
C) Addiction
D) Codependence
Answer: B
Explanation: A) Tolerance means the user requires progressively greater quantities of the substance to achieve the same pleasurable effects.
B) Dependence is a physiologic need for a substance that the client cannot control and that results in withdrawal symptoms if the substance is stopped or withheld. Dependence causes the user to develop a physiologic tolerance for the substance.
C) Addiction is a psychologic or physical need for a substance or process to the extent that the individual will risk negative consequences in an attempt to meet the need.
D) Codependence is a cluster of maladaptive behaviors exhibited by the significant others of a substance-abusing individual that serves to enable and protect the abuse.
Page Ref: 1694
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 22.2. Summarize manifestations of substance use disorders.
MNL LO: Analyze the concept of addiction and its application to nursing care.

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14) An adolescent attends behavioral therapy sessions. On which principle is this treatment modality based?
A) Reinforcement
B) Use of self-statements
C) Resolving negating life events
D) Regulation of destructive emotions
Answer: A
Explanation: A) In behavioral therapy, clients learn techniques to modify or change their addictive behaviors. Classic behavioral modification therapy is typically used with adolescents. It is based on the principle that all behavior has specific consequences and can be changed by conditioning–a process of reinforcement.
B) Cognitive-behavioral therapy (CBT) replaces maladaptive or inappropriate behaviors and faulty cognitions with thoughts and self-statements that promote adaptive behavior.
C) Rational emotive behavior therapy (REBT), is an active, solution-oriented therapy that focuses on resolving emotional, cognitive, and behavioral problems resulting from faulty evaluation of negative life events.
D) Dialectical behavior therapy (DBT) teaches clients how to regulate destructive emotions, practice mindfulness, and better tolerate distress.
Page Ref: 1706
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 22.7. Summarize collaborative therapies used by interprofessional teams for patients with substance use disorders.
MNL LO: Analyze the concept of addiction and its application to nursing care.

15) A client has been admitted to a healthcare facility for treatment of alcohol use. For which reason will the client be prescribed carbamazepine?
A) The client is addicted to opioids.
B) The client is experiencing cravings for nicotine.
C) The client has high levels of anxiety.
D) The client is experiencing withdrawal-related seizure activity.
Answer: D
Explanation: A) Opioid withdrawal usually does not produce seizures.
B) Clients who are experiencing nicotine cravings may receive nicotine replacement therapy and/or antidepressants, not carbamazepine,
C) Withdrawal-related anxiety may be treated with benzodiazepines, not antiseizure drugs.
D) Carbamazepine is an antiseizure medication that is used to reduce and control seizure activity resulting from withdrawal from alcohol.
Page Ref: 1704
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 22.7. Summarize collaborative therapies used by interprofessional teams for patients with substance use disorders.
MNL LO: Analyze the concept of addiction and its application to nursing care.

16) A client with alcoholism is receiving court-ordered care in a residential treatment facility. After alcohol is discovered in the room, the client states, "It is not mine." Which responses by the nurse are appropriate in this situation? **Select all that apply.**
A) "You will lose your day pass privileges for this Sunday."
B) "We have a video of you accepting the alcohol from your brother."
C) "What do you think about sharing this at AA tonight?"
D) "You won't be allowed to go to dinner tonight."
E) "You have violated the expectations for treatment."
Answer: A, B, C, E
Explanation: A) Losing privileges is an appropriate consequence for a violation in boundaries.
B) Used with care and a calm attitude, confrontation interferes with the client's ability to use denial or rationalization.
C) Participation in AA will provide peer feedback and can help the client remain accountable for behavior.
D) Withholding food is inappropriate, particularly for a client with potential nutritional deficits.
E) Limit setting teaches the individual that there are choices, but there are also consequences for making poor decisions. The goal of setting limits is to teach patients how to consistently make good decisions.
Page Ref: 1703-1704
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 22.6. Analyze independent interventions nurses can implement for patients with substance use disorders.
MNL LO: Analyze the concept of addiction and its application to nursing care.

17) The nurse is concerned about potential substance abuse by a coworker. Which coworker's behaviors would place the clients on the unit at risk for injury?
A) The nurse in question frequently volunteers to give medications to clients.
B) The nurse in question prefers not to be the "medication nurse" on the shift.
C) The nurse in question declines to take scheduled breaks.
D) The nurse in question frequently requests the largest client care assignment for the shift.
Answer: A
Explanation: A) Frequently volunteering to give medications or having excessive medication wasting could be a sign that a nurse is using or diverting drugs.
B) The nurse who does not want to be the medication nurse is unlikely to be using substances.
C) Taking frequent or lengthy breaks might signal substance abuse.
D) The nurse who is unable or unwilling to manage a large client care assignment could be a substance abuser.
Page Ref: 1710
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 22.2. Summarize manifestations of substance use disorders.
MNL LO: Analyze the concept of addiction and its application to nursing care.

18) The nurse is collecting data on clients at a clinic. One client has risk factors for substance abuse. Which findings indicate to the nurse that a client is using a substance? **Select all that apply.**

A) Dilated pupils
B) Odor of alcohol on the breath
C) Frequent accidents or falls
D) Extremely low body weight
E) Dressed in jeans and a t-shirt

Answer: A, B, D

Explanation: A) Physical signs of substance abuse include dilated or constricted pupils.
B) Physical signs of substance abuse include an odor of alcohol on the breath.
C) Frequent accidents or falls are behavioral signs of substance abuse.
D) Physical signs of substance abuse include poor nutritional status.
E) Wearing jeans and a t-shirt is not indicative of substance abuse.

Page Ref: 1702

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 22.2. Summarize manifestations of substance use disorders.

MNL LO: Analyze the concept of addiction and its application to nursing care.

Exemplar 22.A Alcohol Abuse

1) The nurse is providing care to a client diagnosed with alcoholism. The client's physical examination reveals a BMI of 18. Which prescription does the nurse anticipate to manage the client's nutritional status?
A) Sertraline
B) Methadone
C) Naloxone
D) Multivitamin with folic acid
Answer: D
Explanation: A) Sertraline is used to reduce anxiety and stabilize mood.
B) Methadone is prescribed to manage heroin cravings.
C) Naloxone is used to manage an opiate overdose.
D) A client with alcohol dependence may suffer from numerous nutritional deficiencies, including deficiencies in thiamine, folic acid, vitamin A, magnesium, and zinc. A multivitamin may be prescribed to help with these deficiencies.
Page Ref: 1709
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 22.A. Analyze manifestations and treatment considerations for patients who abuse alcohol. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with an alcohol use disorder.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with alcohol abuse.

2) A college student attends a seminar on alcohol abuse. Which statement would alert the nurse that the student needs more education?
A) "The children of alcoholics have a lower risk of becoming alcoholic."
B) "Native Americans are at higher risk of becoming alcoholic."
C) "Married college graduates are less likely to become alcoholics."
D) "Childless people are less likely to become alcoholics."
Answer: A
Explanation: A) Genetic and environmental factors place children of alcoholics at greater risk for developing alcoholism.
B) Genetic and environmental factors place Native Americans at greater risk for developing alcoholism.
C) Married people are less likely to become alcoholics.
D) People with children are less likely to become alcoholics.
Page Ref: 1714
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: IX.3. 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 22.A. Analyze manifestations and treatment considerations for patients who abuse alcohol. Compare the risk factors and prevention of alcohol abuse.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with alcohol abuse.

3) The nurse assesses a client with a history of alcoholism who is hospitalized with anorexia, dysphagia, odynophagia, and chest pressure after eating. Which problem is a priority for this client?
A) Inadequate coping
B) Undernutrition
C) Denial
D) Confusion
Answer: B
Explanation: A) Inadequate coping is a problem associated with substance abuse, but it is not suggested by the symptoms given here.
B) A client with anorexia and a history of alcoholism is at risk for undernutrition. The client's symptoms of dysphagia, odynophagia, and chest pressure after eating further support this problem.
C) The client's symptoms do not support the problem of denial.
D) The client's symptoms do not support the problem of confusion.
Page Ref: 1721
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 22.A. Analyze manifestations and treatment considerations for patients who abuse alcohol. Apply the nursing process in providing culturally competent care to an individual with alcohol use disorder.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with alcohol abuse.

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4) A pregnant client asks if drinking alcohol during a family party is permitted. Which response by the nurse is appropriate?
A) "Drinking a few glasses of wine will not be a problem."
B) "Consuming alcohol during pregnancy can cause the baby to be born without limbs."
C) "Drinking any alcoholic beverages of any type during pregnancy puts your baby at risk for injury."
D) "Wine is acceptable but not hard liquor."
Answer: C
Explanation: A) Women should be encouraged to drink no alcohol at all during pregnancy.
B) There is no evidence that alcohol intake during pregnancy results in a fetus without limbs.
C) Drinking any alcohol, no matter what type and what quantity, during pregnancy increases the risk for accidents and damage to the infant.
D) Wine can put the mother and fetus at risk as much as hard liquor.
Page Ref: 1719
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 22.A. Analyze manifestations and treatment considerations for patients who abuse alcohol. Differentiate the care of patients across the lifespan who abuse alcohol.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with alcohol abuse.

5) The nurse is evaluating a list of outcome goals for a client with alcoholism who is being discharged from a detoxification program. Which outcomes are appropriate for this client? **Select all that apply.**
A) The client refrains from using alcohol.
B) The client displays new coping mechanisms.
C) The client confronts codependent behavior from family.
D) The client controls anxiety.
E) The client improves nutritional status.
Answer: A, B, D, E
Explanation: A) Refraining from using alcohol is an appropriate goal for a client being discharged from a detoxification program.
B) Displaying new coping mechanisms is an appropriate goal for a client being discharged from a detoxification program.
C) Confronting codependent behavior from family would not be an appropriate goal after treatment for alcohol use.
D) Controlling anxiety is an appropriate goal for a client being discharged from a detoxification program.
E) Improving nutritional status is an appropriate goal for a client being discharged from a detoxification program.
Page Ref: 1722
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 22.A. Analyze manifestations and treatment considerations for patients who abuse alcohol. Apply the nursing process in providing culturally competent care to an individual with alcohol use disorder.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with alcohol abuse.

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6) The nurse is providing preconception counseling and education to an adult client with no prior pregnancies. Which client statement indicates that teaching has been effective?
A) "I can continue to drink alcohol throughout my pregnancy."
B) "One beer once per week will not harm the fetus."
C) "I don't need to stop drinking alcohol until my pregnancy is confirmed."
D) "I can't drink alcohol while breastfeeding, because it will pass into my breast milk."
Answer: D
Explanation: A) Women should stop drinking alcohol when they attempt to become pregnant.
B) It is not known how much alcohol will cause fetal damage; therefore, any amount of alcohol, even one beer, during pregnancy is contraindicated.
C) Women should stop drinking alcohol when they attempt to become pregnant.
D) Alcohol passes readily into breast milk; therefore, women should abstain from alcohol while breastfeeding, or the milk should be pumped and dumped after alcohol consumption.
Page Ref: 1719
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 22.A. Analyze manifestations and treatment considerations for patients who abuse alcohol. Differentiate the care of patients across the lifespan who abuse alcohol.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with alcohol abuse.

7) The nurse is conducting a health history and wants to determine the client's level of alcohol use. Which question will provide the greatest amount of information?

A) "Are you a heavy drinker?"
B) "How many alcoholic beverages do you drink each day?"
C) "Is alcohol use a concern for you?"
D) "Drinking doesn't cause any problems for you, does it?"

Answer: B

Explanation: A) Asking closed questions that can be answered with a "yes" or "no" will limit the information obtained by the nurse.

B) Open-ended questions will elicit the greatest amount of information about the client's alcohol use.

C) Asking closed questions that can be answered with a "yes" or "no" will limit the information obtained by the nurse.

D) Asking closed questions that can be answered with a "yes" or "no" will limit the information obtained by the nurse.

Page Ref: 1720

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 22.A. Analyze manifestations and treatment considerations for patients who abuse alcohol. Apply the nursing process in providing culturally competent care to an individual with alcohol use disorder.

MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with alcohol abuse.

8) Which sign or symptom would *least* likely be observed in a client who is experiencing alcohol withdrawal syndrome?
A) Anorexia
B) Hypotension
C) Visual hallucinations
D) Hyperthermia
Answer: B
Explanation: A) Signs and symptoms of alcohol withdrawal syndrome include anorexia.
B) Hypotension is not associated with alcohol withdrawal syndrome.
C) Signs and symptoms of alcohol withdrawal syndrome include hallucinations.
D) Signs and symptoms of alcohol withdrawal syndrome include hyperthermia.
Page Ref: 1717
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 22.A. Analyze manifestations and treatment considerations for patients who abuse alcohol. Identify the clinical manifestations of alcohol withdrawal.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with alcohol abuse.

9) Which tool is used to assess the severity of symptoms of acute alcohol withdrawal?

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A) CIWA-Ar
B) AUDIT-C
C) CAGE
D) SASQ
Answer: A
Explanation: A) The Clinical Institute Withdrawal Assessment for Alcohol—Revised (CIWA-Ar) scale is used to assess the severity of symptoms of acute alcohol withdrawal.
B) The abbreviated Alcohol Use Disorders Identification Test—Consumption (AUDIT-C) tool is used to assess alcohol use in adults.
C) The CAGE questionnaire is useful to detect alcohol dependence.
D) The Single Alcohol Screening Question (SASQ) is used to assess alcohol use in adults.
Page Ref: 1704
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 22.A. Analyze manifestations and treatment considerations for patients who abuse alcohol. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with an alcohol use disorder.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with alcohol abuse.

10) The nurse is asked to explain the effects of alcohol use between males and females. With which information about females should the nurse respond?

A) They are less likely to begin regularly using alcohol at an early age.

B) They are likely to wait a greater number of years before entering treatment for alcohol abuse.

C) They are less susceptible to alcohol-related organ damage.

D) They are likely to experience greater cognitive impairment from alcohol consumption.

Answer: D

Explanation: A) No gender difference has been noted for age at onset of regular alcohol use, but women typically use alcohol for fewer years than men before entering treatment.

B) No gender difference has been noted for age at onset of regular alcohol use, but women typically use alcohol for fewer years than men before entering treatment.

C) Women are more susceptible to alcohol-related organ damage.

D) Women experience greater cognitive impairment from alcohol.

Page Ref: 1719

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation

Learning Outcome: 22.A. Analyze manifestations and treatment considerations for patients who abuse alcohol. Differentiate the care of patients across the lifespan who abuse alcohol.

MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with alcohol abuse.

11) Which intervention would be most appropriate when caring for clients who are experiencing acute alcohol withdrawal?
A) Avoiding administration of benzodiazepines
B) Reassuring clients who are experiencing delusions that you share their beliefs
C) Reducing environmental stimuli to the greatest extent possible
D) Arguing with clients who are experiencing visual hallucinations in an attempt to prove that what they are seeing is not real
Answer: C
Explanation: A) The nurse should administer benzodiazepines according to the detoxification protocol to help minimize the discomfort of withdrawal symptoms.
B) The nurse should express reasonable doubt if clients relay suspicious or paranoid beliefs.
C) When caring for clients who are experiencing acute alcohol withdrawal, the nurse should minimize environmental stimuli to decrease the likelihood of agitation.
D) The nurse should avoid arguing with clients who are experiencing delusions or hallucinations.
Page Ref: 1722
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 22.A. Analyze manifestations and treatment considerations for patients who abuse alcohol. Apply the nursing process to promote patient safety during withdrawal and detoxification.

MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with alcohol abuse.

Exemplar 22.B Nicotine Addiction

1) The nurse is providing care to a client who admits to smoking two packs of cigarettes per day for 34 years. The client also has a history of intermittent claudication, chronic bronchitis, and emphysema. After 6 weeks of smoking cessation, the client reports that he is frequently "yelling" at his spouse and "flying off the handle." Which effects of cigarette smoking are associated with the data the nurse has collected from the client? **Select all that apply.**
A) Nicotine causes destruction of the alveoli.
B) Smoking triggers the release of epinephrine, which causes vasoconstriction.
C) Dopaminergic processes are implicated in nicotine withdrawal.
D) The tar in cigarettes can cause the mucus production seen in chronic bronchitis.
E) Tobacco use leads to atherosclerosis.
Answer: B, C, D, E
Explanation: A) Tar and other chemicals, not nicotine, cause the destruction of the alveoli seen in emphysema.
B) Nicotine causes the release of dopamine (a precursor to norepinephrine) and epinephrine. These substances trigger vasoconstriction, which exacerbates intermittent claudication.
C) Dopaminergic processes have a role in regulating the reinforcing effects of nicotine, making cessation difficult and contributing to withdrawal symptoms including nervousness, restlessness, irritability, impatience, and increased hostility.
D) Tar and other chemicals cause productive cough seen in chronic bronchitis.
E) Tobacco use also causes atherosclerosis, which is seen in intermittent claudication.
Page Ref: 1725
Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 22.B. Analyze manifestations and treatment considerations for patients with an addiction to nicotine. Describe the pathophysiology of nicotine addiction.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with nicotine use.

2) A 60-year-old client with heart disease tells the nurse, "I am too old to quit smoking now." Which response by the nurse is appropriate?
A) "You probably won't have any benefits if you quit now."
B) "Stopping now will reduce any symptoms you have from smoking."
C) "It's odd for someone your age to be smoking."
D) "It would be hard for you to quit now."
Answer: B
Explanation: A) Any elimination of smoking will improve the client's health.
B) Even clients who quit smoking during their 60s are at substantially decreased risk of death, relative to people who continue to smoke.
C) In 2018, 8.4% of adults aged 65 and older were current smokers.
D) The nurse should be supportive and help the client with smoking cessation actions.
Page Ref: 1728
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 22.B. Analyze manifestations and treatment considerations for patients with an addiction to nicotine. Apply the nursing process in providing culturally competent care to an individual who is addicted to nicotine.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with nicotine use.

3) The nurse is teaching a class of adolescents about smoking. Which point is most important to convey to this audience?
A) Teenagers and young adults are not strongly influenced by tobacco advertising.
B) Smoking is a major cause of lung cancer.
C) Increasing the cost of cigarettes is not an effective deterrent to smoking.
D) Few young people who smoke regularly during their teenage years continue to use tobacco as adults.
Answer: B
Explanation: A) Teenagers and young adults tend to be strongly influenced by both tobacco advertising and counter advertising mass media campaigns.
B) Smoking is a main cause of lung cancer, and it also directly contributes to the development of many other diseases, including heart disease and stroke.
C) Increasing the cost of cigarettes has been found to be an effective deterrent to smoking.
D) Teenagers who smoke regularly tend to continue smoking during adulthood, which makes prevention particularly important among the adolescent population.
Page Ref: 1727
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 22.B. Analyze manifestations and treatment considerations for patients with an addiction to nicotine. Compare the risk factors and prevention of nicotine addiction.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with nicotine use.

4) The nurse is planning care for a client with esophageal cancer caused by years of nicotine abuse. Which problem would be the priority for this client?
A) Anxiety
B) Denial
C) Inadequate coping skills
D) Impaired airway clearance
Answer: D
Explanation: A) There is no evidence that the client will experience anxiety.
B) Denial would not be a priority with this client.
C) There is no evidence of the client having inadequate coping skills.
D) The nurse should anticipate that a client with esophageal cancer related to tobacco use may have issues with airway edema. Because proper breathing and oxygenation are crucial, impaired airway clearance would be the priority problem.
Page Ref: 1729
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | Nursing Process: Diagnosis
Learning Outcome: 22.B. Analyze manifestations and treatment considerations for patients with an addiction to nicotine. Apply the nursing process in providing culturally competent care to an individual who is addicted to nicotine.

MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with nicotine use.

5) The nurse works at a clinic that provides care to a community with a high population of smokers. The nurse is planning an educational session entitled "Tips for Quitting." Which action by the nurse is appropriate for inclusion in this session?
A) Telling participants that smoking is an unacceptable behavior
B) Making sure participants are aware of the increased risk of liver disease and esophageal cancer associated with smoking
C) Reviewing available pharmacologic adjuncts to cessation with participants
D) Recommending that participants seek hypnosis at a local dinner theater to aid in their attempts at smoking cessation
Answer: C
Explanation: A) Simply telling the participants that smoking is unacceptable is not effective in promoting wellness.
B) Although it is true that smoking contributes to cancer and liver disease, this information will not help participants identify and apply effective strategies for tobacco cessation.
C) The nurse should include information about available pharmacologic adjuncts to cessation in a "Tips for Quitting" session.
D) Hypnosis can be useful for clients who are trying to quit smoking, but the nurse should recommend that clients seek hypnosis only from a trained healthcare professional.
Page Ref: 1729
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 22.B. Analyze manifestations and treatment considerations for patients with an addiction to nicotine. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual who abuses nicotine.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with nicotine use.

6) The nurse is providing care to a client with a history of chronic obstructive pulmonary disease (COPD) who wants help and information regarding nicotine addiction and ways to quit smoking. After the nurse has provided education regarding smoking cessation, which client statement would indicate appropriate understanding of the information presented?
A) "I will keep a pack of cigarettes in my closet in case I need it."
B) "I will taper off smoking gradually."
C) "I will chew sugar-free gum when I want a cigarette."
D) "I will eat a snack when I am feeling nervous."
Answer: C
Explanation: A) Keeping cigarettes close indicates the client is not wholly committed to cessation.
B) Tapering off smoking indicates the client is not wholly committed to cessation.
C) When providing education regarding smoking cessation, it is important for the nurse to include adaptive coping mechanisms for the client to use during times of stress. Expressing the intention to use a healthy coping mechanism–such as chewing sugar-free gum–when the urge to smoke arises indicates appropriate understanding of the information presented.
D) Eating when stressed may lead the client to substitute eating for smoking, which is a form of denial.
Page Ref: 1729
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 22.B. Analyze manifestations and treatment considerations for patients with an addiction to nicotine. Apply the nursing process in providing culturally competent care to an individual who is addicted to nicotine.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with nicotine use.

7) The nurse is providing education to a client who wants to quit smoking. Which statements are appropriate for the nurse to include in the teaching session? **Select all that apply.**
A) "There is no adverse risk if you choose to smoke while wearing a nicotine patch."
B) "Bupropion (Zyban) is used to suppress the craving for tobacco."
C) "A piece of nicotine gum should be chewed for 5 minutes of every waking hour, then held in the cheek."
D) "Most people quit smoking several times before they are successful."
E) "Alternative therapies can help reduce the stress that accompanies smoking cessation."
Answer: B, D, E
Explanation: A) A client who is wearing a nicotine patch must not smoke because of increased risk for cardiovascular problems, including myocardial infarction.
B) Bupropion is used to suppress the craving for tobacco and may be a viable option for this client.
C) The proper use of nicotine gum is to take one piece when the urge to smoke occurs, up to 9-12 times daily. The gum should be chewed several times to soften it, then held in the buccal space for at least 30 minutes to absorb the medication.
D) When teaching clients about smoking cessation, the nurse should emphasize that most people who quit smoking try to quit several times before they are successful.
E) The nurse should always consider alternative therapies in addition to traditional therapies, because they may help the client better deal with the stress that accompanies smoking cessation.
Page Ref: 1729
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 22.B. Analyze manifestations and treatment considerations for patients with an addiction to nicotine. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual who abuses nicotine.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with nicotine use.

8) The nurse is caring for a client who smokes cigarettes and wants information about nicotine replacement therapy (NRT). Which statement is appropriate for the nurse to include in the teaching session?

A) "Over-the-counter NRT products include transdermal patches, gums, nicotine inhalers, and nasal sprays."

B) "NRT helps relieve the psychologic and physiologic effects of nicotine withdrawal."

C) "NRT does not address addictive behavior."

D) "Using NRT in conjunction with a smoking cessation program is no more effective than using NRT alone."

Answer: C

Explanation: A) Over-the-counter NRT products include transdermal patches and gums; nicotine inhalers and nasal sprays are available by prescription only.

B) Although NRT helps relieve some physiologic effects of nicotine withdrawal, it does not address the psychologic effects.

C) NRT does not address addictive behavior.

D) Using NRT in conjunction with a smoking cessation program is more effective than using NRT alone.

Page Ref: 1727

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

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Learning Outcome: 22.B. Analyze manifestations and treatment considerations for patients with an addiction to nicotine. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual who abuses nicotine.

MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with nicotine use.

9) A nurse is caring for a client with congestive heart failure (CHF) who currently smokes cigarettes and has a 50-pack-year smoking history. When providing smoking cessation education to this client, which statements regarding the pathophysiology of nicotine use are appropriate? **Select all that apply.**
A) "In low doses, nicotine stimulates nicotinic receptors in the brain to release dopamine."
B) "In high doses, nicotine stimulates the parasympathetic system to release epinephrine, causing vasoconstriction."
C) "Initially, nicotine increases mental alertness and cognitive ability."
D) "Nicotine is a nonpsychoactive substance found in tobacco."
E) "Gradual reduction of nicotine intake appears to be the best method of cessation."
Answer: A, C
Explanation: A) In low doses, nicotine stimulates nicotinic receptors in the brain to release dopamine and epinephrine, causing vasoconstriction.
B) Nicotine stimulates nicotinic receptors in the brain to release dopamine and epinephrine and is associated with the sympathetic nervous system, not the parasympathetic nervous system.
C) Nicotine is a psychoactive substance found in tobacco. Gradual reduction in nicotine use seems to prolong the suffering of withdrawal and is not a recommended method of cessation.
D) Nicotine is a psychoactive substance found in tobacco.
E) Gradual reduction in nicotine use seems to prolong the suffering of withdrawal and is not a recommended method of cessation.
Page Ref: 1725
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 22.B. Analyze manifestations and treatment considerations for patients with an addiction to nicotine. Describe the pathophysiology of nicotine addiction.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with nicotine use.

10) The nurse who works in an outpatient primary care clinic is caring for a client with asthma who has an 80-pack-year smoking history. When assessing the client's current use of nicotine, which question is most appropriate?
A) "Have you tried a nicotine patch for quitting smoking?"
B) "Do you smoke cigarettes with filters or without?"
C) "Do you smoke immediately after waking up?"
D) "What prior attempts have you made to quit using nicotine?"
Answer: D
Explanation: A) Asking about a nicotine patch does not assess the client's current use of nicotine.
B) Asking about the type of cigarette does not assess the client's current use of nicotine.
C) Asking when the client smokes after sleeping does not assess the client's current use of nicotine.
D) Appropriate assessment questions should be open-ended and allow the client to elaborate on the answers. Of the choices provided, only "What prior attempts have you made to quit using nicotine?" meets these criteria.
Page Ref: 1728
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 22.B. Analyze manifestations and treatment considerations for patients with an addiction to nicotine. Apply the nursing process in providing culturally competent care to an individual who is addicted to nicotine.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with nicotine use.

11) The nurse is teaching a client about the effects of smoking during pregnancy. Upon conclusion of the teaching session, which client statement would suggest that further education is necessary?
A) "When a pregnant woman smokes, the concentration of nicotine in the fetus can be even higher than that in the woman's own body."
B) "Smoking during pregnancy is associated with an increased risk of placental problems."
C) "Prenatal nicotine exposure is linked to attention deficits and learning difficulties during childhood."
D) "Although women who smoke during pregnancy are at higher risk for respiratory disease later in life, their children are not."
Answer: D
Explanation: A) Nicotine crosses the placenta, and fetal concentrations of nicotine can be 15% higher than maternal concentrations.
B) Smoking during pregnancy is associated with increased risk for spontaneous abortion, preterm delivery, respiratory disease, immune system difficulties, and cancer later in life.
C) Prenatal tobacco exposure has been associated with serious neurodevelopmental and behavioral consequences in children, including attention deficits and issues with learning and memory.
D) Smoking during pregnancy is associated with increased risk for spontaneous abortion, preterm delivery, respiratory disease, immune system difficulties, and cancer later in life.
Page Ref: 1728
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 22.B. Analyze manifestations and treatment considerations for patients with an addiction to nicotine. Differentiate care of patients across the lifespan who abuse nicotine.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with nicotine use.

12) Which statement is true about vaping?
A) Vaping is a safe alternative to cigarette smoking.
B) E-cigarettes are less popular among teenagers than cigarettes and other traditional tobacco products.
C) Vaping has been linked to e-cigarette product use—associated lung injury.
D) Throughout the United States, vaping is subject to the same regulations as cigarette smoking.
Answer: C
Explanation: A) It remains to be proven whether e-cigarettes are actually safe or simply less harmful than tobacco.
B) The popularity of e-cigarettes is exploding among teenagers and young adults.
C) E-cigarette product use—associated lung injury (EVALI) has been linked with e-cigarette (vaping) products containing vitamin E acetate or tetrahydrocannabinol."
D) In many parts of the United States, vaping is unregulated.
Page Ref: 1725
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 22.B. Analyze manifestations and treatment considerations for patients with an addiction to nicotine. Compare the risk factors and prevention of nicotine addiction.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with nicotine use.

13) For which reason is smoking particularly dangerous for clients with atherosclerosis?
A) Smoking causes a direct increase in HDL cholesterol, which further contributes to plaque buildup.
B) Smoking causes vasoconstriction, which further impairs tissue oxygenation.
C) Smoking causes a direct increase in total cholesterol, which further contributes to plaque buildup.
D) Smoking causes a decrease in blood pressure, which further impairs tissue oxygenation.
Answer: B
Explanation: A) Smoking does not directly affect cholesterol levels.
B) Smoking does lead to vasoconstriction which further impairs tissue oxygenation in clients with atherosclerosis.
C) Smoking does not directly affect cholesterol levels.
D) Smoking causes an increase in blood pressure.
Page Ref: 1725
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 22.B. Analyze manifestations and treatment considerations for patients with an addiction to nicotine. Describe the pathophysiology of nicotine addiction.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with nicotine use.

14) Which characteristic would increase a client's risk of unpleasant side effects from nicotine replacement therapy (NRT)?
A) Male gender
B) Heavy smoking prior to beginning NRT
C) Low body weight
D) History of failed attempts at smoking cessation
Answer: C
Explanation: A) Male gender does not increase the risk of side effects.
B) Some transdermal patches and gums are designed for heavy smokers.
C) If clients have low body weight or did not smoke heavily prior to starting NRT, they may experience unpleasant side effects from ingesting too much nicotine.
D) A history of failed attempts at smoking cessation does not increase the risk of side effects.
Page Ref: 1727
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 22.B. Analyze manifestations and treatment considerations for patients with an addiction to nicotine. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual who abuses nicotine.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with nicotine use.

Exemplar 22.C Substance Abuse

1) The nurse is caring for a client who is diagnosed with a cocaine addiction. For which additional disorder should the nurse assess this client?
A) Anxiety
B) Diabetes
C) Weight gain
D) Kidney stones
Answer: A
Explanation: A) Substance use or abuse commonly co-occurs with other mental health disorders, such as anxiety and depression. In fact, approximately 20% of Americans with an anxiety or mood disorder such as depression also have an alcohol or other substance use disorder.
B) Diabetes is not linked to substance abuse.
C) Weight gain is not linked to substance abuse.
D) Kidney stones are not linked to substance abuse.
Page Ref: 1732
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Compare the risk factors and prevention of substance abuse.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

2) A pregnant client experiences abruptio placentae. The father of the baby asks the nurse why this has happened. Which risk factor in the client's history is the most likely cause for this condition?

A) Maternal use of marijuana during pregnancy
B) Genetic history
C) Maternal use of cocaine during pregnancy
D) Low maternal folic acid levels

Answer: C

Explanation: A) Marijuana use is associated with an increased risk of intrauterine growth restriction (IUGR), but not with an increased rate of placental abruption.
B) Genetic history does not affect the risk for abruption.
C) Maternal use of cocaine during pregnancy puts a woman at risk for placental abruption.
D) Low folic acid levels would contribute to neural tube problems.

Page Ref: 1740
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Differentiate care of patients across the lifespan who abuse substances.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

3) A college student is incoherent after reportedly taking alprazolam with beer. For which health problem should the nurse observe in this client?
A) Hallucinations
B) Respiratory depression
C) Seizure activity
D) Signs of withdrawal
Answer: B
Explanation: A) Hallucinations do not pose as great a risk for this client as respiratory depression.
B) Alprazolam is a central nervous system (CNS) depressant. CNS depressants and alcohol are a lethal combination, because clients who ingest both types of substances are at risk for varying degrees of sedation, up to coma and death.
C) Seizure activity does not pose as great a risk for this client as respiratory depression.
D) Signs of withdrawal do not pose as great a risk for this client as respiratory depression.
Page Ref: 1691
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Identify clinical manifestations of substance abuse.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

4) The nurse is completing a health history for an adolescent client and determines that the client would benefit from teaching about substance abuse. Which client statements caused the nurse to come to this conclusion? **Select all that apply.**
A) "I drink alcohol with my friends on the weekends."
B) "I smoke cigarettes on a daily basis."
C) "I use my seat belt every time I ride in a car."
D) "I started having sex when I was 13."
E) "I get all A's and B's in school."
Answer: A, B, D
Explanation: A) Drinking alcohol is a risk factor for adolescent substance abuse.
B) Smoking cigarettes is a risk factor for adolescent substance abuse.
C) Wearing a seat belt is not a risk factor for substance abuse.
D) Early sexual activity is a risk factor for adolescent substance abuse.
E) Getting good grades is not a risk factor for substance abuse.
Page Ref: 1738
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Differentiate care of patients across the lifespan who abuse substances.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

5) A young adult client is at 28 weeks' gestation. The client's prenatal history reveals past drug abuse, and urine screening indicates recent use of heroin. Which potential health problem should the nurse recognize as the greatest risk to the fetus?
A) Congenital anomalies
B) Abruptio placentae
C) Diabetes mellitus
D) Intrauterine growth restriction (IUGR)
Answer: D
Explanation: A) Congenital anomalies are more commonly associated with use of other drugs, including lithium and dextroamphetamine sulfate.
B) Abruptio placentae is more commonly seen with use of cocaine.
C) Diabetes is an endocrine disorder that is unrelated to drug use and abuse.
D) Women who use opioids such as heroin place their fetus at increased risk for intrauterine growth restriction (IUGR).
Page Ref: 1739
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Differentiate care of patients across the lifespan who abuse substances.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

6) The nurse is providing care to a client with alcohol and opioid dependency. The client's mother states, "I don't understand why my daughter has been prescribed naltrexone, because it causes a high, too, right?" Which response by the nurse is appropriate?
A) "Naltrexone will cause your daughter to become violently ill if she drinks alcohol or abuses drugs."
B) "Naltrexone is less potent than the street drugs your daughter is currently taking and is, therefore, safer."
C) "Naltrexone helps diminish your daughter's cravings for alcohol and opioids."
D) "Naltrexone will prevent your daughter from getting drunk when she drinks."
Answer: C
Explanation: A) Disulfiram, not naltrexone, will cause a person to become violently ill when alcohol is consumed.
B) Naltrexone is not used as an alternative to street drugs.
C) Naltrexone helps reduce cravings for alcohol and opioids by blocking the pathways to the brain that trigger a feeling of pleasure when these substances are used.
D) Naltrexone does not prevent alcohol intoxication.
Page Ref: 1735
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual who abuses substances.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

7) A client is attending a Narcotics Anonymous (NA) program. Which response should the nurse make when the client asks what is the most important initial goal of attending the meetings?

A) "The most important initial goal is to admit that you have a problem."

B) "The most important initial goal is to learn problem-solving skills."

C) "The most important initial goal is to take a personal moral inventory."

D) "The most important initial goal is to make amends to people you have hurt."

Answer: A

Explanation: A) The key initial outcome for clients with a substance use disorder is admitting a problem exists.

B) Learning problem-solving skills is not the most important initial goal of treatment for substance use.

C) A personal moral inventory is not an initial first goal when attending a program for substance use.

D) Making amends to people that have been hurt is not an initial first goal when attending a program for substance use.

Page Ref: 1741

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual who abuses substances.

MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

8) A client is admitted to the emergency department after overdosing on phencyclidine (PCP). Which treatments should the nurse anticipate for this client? **Select all that apply.**
A) Cranberry juice
B) Monitor respiratory status
C) Diazepam
D) Haldol
E) Gastric lavage
Answer: A, B, C, D
Explanation: A) PCP overdose is associated with possible hypertensive crisis, respiratory arrest, hyperthermia, and seizures. Cranberry juice will be provided to help acidify the urine to help excrete the drug.
B) PCP overdose is associated with possible hypertensive crisis, respiratory arrest, hyperthermia, and seizures. The respiratory status should be monitored.
C) PCP overdose is associated with possible hypertensive crisis, respiratory arrest, hyperthermia, and seizures. Diazepam may be prescribed.
D) PCP overdose is associated with possible hypertensive crisis, respiratory arrest, hyperthermia, and seizures. Haldol may be prescribed.
E) Lavage would be an inappropriate treatment for inhalation of any substance, and PCP is usually inhaled in some form.
Page Ref: 1737
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Apply the nursing process in providing culturally competent care to an individual who abuses substances.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

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9) After assessing a new client who admits to opioid addiction, a nursing student expresses the belief that drug addiction is not a real illness because "people who use drugs do it to themselves." Which response by the staff nurse is appropriate?
A) "Sometimes a client doesn't show much effort to change their behavior."
B) "We are legally obligated to provide care, regardless of the cause of a client's illness."
C) "It is important to remain nonjudgmental when caring for any client, even a drug addict."
D) "You are right. I don't know why we bother."
Answer: C
Explanation: A) Even if a client is not currently making much effort toward managing an addiction, the development of a trusting relationship with the nurse helps set the stage for movement toward recovery in the future.
B) Although it is true that nurses are legally obligated to provide care, this response is not client-focused and is therefore inappropriate.
C) Nurses must maintain a nonjudgmental attitude with their clients in order to promote trust and respect.
D) Even if a client is not currently making much effort toward managing an addiction, the development of a trusting relationship with the nurse helps set the stage for movement toward recovery in the future.
Page Ref: 1741
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Apply the nursing process in providing culturally competent care to an individual who abuses substances.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

10) The nurse is caring for a client who has overdosed on cocaine. For which findings should the nurse assess this client? **Select all that apply.**

A) Stroke
B) Arrhythmias
C) Status epilepticus
D) Respiratory arrest
E) Gastrointestinal bleeding

Answer: A, B, C, D

Explanation: A) Cocaine is a powerfully addictive stimulant that increases the risk of stroke.
B) Cocaine is a powerfully addictive stimulant that increases the risk for arrhythmias.
C) Cocaine is a powerfully addictive stimulant that increases the risk for status epilepticus.
D) Cocaine is a powerfully addictive stimulant that increases the risk for respiratory arrest.
E) Gastrointestinal bleeding is not a condition associated with cocaine overdose.

Page Ref: 1734

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment

Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual who abuses substances.

MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

11) A client is admitted for the fourth time in 4 years for opioid detoxification. When planning care for this client, the nurse should consider which pathophysiologic aspect of substance abuse because of its impact on care?

A) Aging can impact the body's ability to handle detoxification from alcohol and drugs.

B) The client's withdrawal may be greater this time than during past detoxifications.

C) The client's dependency might have been greater this time than during past periods of abuse.

D) Increased difficulty with opioid detoxification is likely the result of an addiction to another substance at the same time.

Answer: B

Explanation: A) Aging does not play a role in the detoxification process.

B) Subsequent episodes of withdrawal tend to get progressively worse due to kindling. Kindling refers to long-term changes in brain neurotransmission that occur after repeated detoxifications.

C) There is no evidence to support the suspicion that the client has an increased degree of dependence.

D) There is no evidence to support the suspicion that the client is addicted to additional substances.

Page Ref: 1732

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Describe the pathophysiology of substance abuse.

MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

12) The nurse is caring for a newborn who is being treated in the newborn intensive care unit (NICU) due to complications from exposure to illicit drugs in utero. The newborn is demonstrating signs of neonatal abstinence syndrome. Which illicit drug is likely to blame for the newborn's symptoms?
A) Marijuana
B) PCP
C) Cocaine
D) LSD
Answer: C
Explanation: A) Marijuana causes hyperactivity and poor cognitive function in the newborn.
B) Hallucinogens do not cause neonatal abstinence syndrome.
C) Cocaine causes neonatal abstinence syndrome as the newborn will abruptly withdraw from the cocaine after birth and will need treatment for symptoms.
D) LSD increases the risk for microcephaly and changed facial features in the newborn.
Page Ref: 1740
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Differentiate care of patients across the lifespan who abuse substances.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

13) During a prenatal visit, the nurse suspects that the client has used cocaine. Which clinical manifestations support the nurse's suspicion? **Select all that apply.**
A) Increased appetite
B) Pinpoint pupils
C) Muscle jerks
D) Hyperpyrexia
E) Bradycardia
Answer: C, D
Explanation: A) Increased appetite is not sign of cocaine use.
B) Pinpoint pupils are associated with heroin use.
C) Acute cocaine intoxication manifests as convulsions.
D) Acute cocaine intoxication manifests as hyperpyrexia.
E) Bradycardia is not associated with acute cocaine intoxication.
Page Ref: 1738
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Identify clinical manifestations of substance abuse.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

14) Which finding would the nurse be least likely to assess in a client with chronic, long-term marijuana use?
A) Airway constriction and inflammation
B) Decreased spermatogenesis in males
C) Chronic bronchitis
D) Increased prolactin levels in females
Answer: D
Explanation: A) Chronic long-term marijuana use can lead to airway constriction and inflammation.
B) Cannabis use causes decreased spermatogenesis and testosterone levels in males.
C) Chronic long-term marijuana use can lead to acute and chronic bronchitis.
D) Cannabis use suppresses follicle-stimulating, luteinizing, and prolactin hormones in females.
Page Ref: 1733
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Identify clinical manifestations of substance abuse.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

15) In which way should the nurse interpret a client who has high scores on the Objective Opiate Withdrawal Scale (OOWS) and the Subjective Opiate Withdrawal Scale (SOWS)?
A) Elevated risk for substance abuse and addiction.
B) Low risk for substance abuse and addiction.
C) Experience particularly intense symptoms of substance withdrawal.
D) Experience relatively mild symptoms of substance withdrawal.
Answer: C
Explanation: A) The Objective Opiate Withdrawal Scale (OOWS) and Subjective Opiate Withdrawal Scale (SOWS) are not used to determine the risk for substance abuse and addiction.
B) The Objective Opiate Withdrawal Scale (OOWS) and the Subjective Opiate Withdrawal Scale (SOWS) are not used to determine the risk for substance abuse and addiction.
C) The Objective Opiate Withdrawal Scale (OOWS) has the nurse rate 13 common, physically observable signs of opiate withdrawal as being either absent or present. The Subjective Opiate Withdrawal Scale (SOWS) asks the client to rate 16 symptoms on a scale of 0 (not at all) to 4 (extremely). In either case, the summed total score can be used to assess the intensity of opiate withdrawal and determine the extent of a client's physical dependence on opioids. Higher scores mean a more intense withdrawal and more physical dependence.
D) High scores on the Objective Opiate Withdrawal Scale (OOWS) and Subjective Opiate Withdrawal Scale (SOWS) indicates intense symptoms of substance withdrawal and not mild symptoms of withdrawal.
Page Ref: 1742
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 22.C. Analyze manifestations and treatment considerations for patients who abuse substances. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual who abuses substances.
MNL LO: Demonstrate understanding of the concept of addiction in the care of a patient with substance abuse.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 23 Cognition

The Concept of Cognition

1) The family of an older adult client is concerned about the changes in the client's behavior. The client used to be a wonderful cook but now cannot even remember how to use a blender. For which causes of impaired cognitive function should the nurse assess the client? **Select all that apply.**
A) Obesity
B) Nutritional deficiencies
C) Medication reactions
D) Stroke
E) Snoring
Answer: B, C, D
Explanation: A) Obesity is not identified as causing impaired cognitive functioning.
B) Dementia can be caused or exacerbated by other conditions and variables, including nutritional deficiencies.
C) Dementia can be caused or exacerbated by other conditions and variables, including medications.
D) Dementia can be caused or exacerbated by other conditions and variables, including any conditions that compromise oxygenation and perfusion such as a stroke.
E) Snoring is not identified as causing impaired cognitive functioning.
Page Ref: 1759

Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 23.2. Differentiate alterations in cognition.
MNL LO: Analyze the concept of cognition and its application to nursing care.

2) The nurse is assessing an older adult client and observes that the client is having several cognitive problems, including memory and attention deficits and fluctuating levels of orientation. The nurse confirms with the family that the client's symptoms developed over a several-year period. The client's symptoms are commonly observed with which condition?

A) Depression

B) Dementia

C) Intellectual disability

D) Delirium

Answer: B

Explanation: A) Depression is a mood disorder that is characterized by a dysphoric mood or loss of interest in usual activities.

B) Dementia is a chronic progressive disorder characterized by memory impairments that develop slowly over a longer period of time.

C) Intellectual disability is defined as significant limitation in intellectual functioning and adaptive behaviors that occurs before the age of 18.

D) Delirium is an acute, abrupt-onset condition characterized by prominent disorientation, impaired attention, and memory deficits.

Page Ref: pp. 1759

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 23.2. Differentiate alterations in cognition.

MNL LO: Analyze the concept of cognition and its application to nursing care.

3) An older adult client comes into the clinic for a pneumonia vaccine. During the client interview, the client reports occasionally having difficulty remembering some words, but denies any other concerns. The client is alert and oriented to time, person, and place, and most responses are appropriate. In which way should the nurse describe this client's cognitive changes?

A) Memory impairment that may be related to cerebral ischemia
B) Normal signs of aging
C) Indicators of depression in the elderly
D) Early symptoms of dementia

Answer: B

Explanation: A) The changes described for this client are not symptoms of ischemia.

B) Older adults typically have more difficulty with cognitive functions, such as word retrieval and episodic memory; however, the impact on overall cognitive function should be minimal. The changes described for this client are normal signs of aging.

C) Depression would show signs of flat affect, or withdrawal, and ischemia may show additional neurologic deficits.

D) Dementia may present with additional symptoms of memory loss related to orientation and completing day-to-day tasks.

Page Ref: 1771

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 23.5. Differentiate common assessment procedures and tests used to examine cognition.

MNL LO: Analyze the concept of cognition and its application to nursing care.

4) While assessing the cognitive status of a school-age child, the nurse notes that the child was unable to perform basic mathematical problems and unable to name several former presidents of the United States. Prior to considering the possibility that this client has cognitive issues, which factor should be reviewed?
A) The child's age and developmental status
B) The child's living arrangements with separated parents
C) The child's currency of vaccinations
D) The child's hobbies performed in leisure time
Answer: A
Explanation: A) The nurse must consider a pediatric client's level of cognitive development before asking questions that involve calculation, judgment, or abstract thought. Even children with normal cognition will be unable to respond appropriately if they have not yet achieved the level of development necessary for these activities.
B) The child's home environment will not explain why the child is unable to correctly respond to questions having to do with complicated math or history.
C) The child's currency of vaccinations will not explain why the child is unable to correctly respond to questions having to do with complicated math or history.
D) The child's hobbies will not explain why the child is unable to correctly respond to questions having to do with complicated math or history.
Page Ref: 1770
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 23.5. Differentiate common assessment procedures and tests used to examine cognition.
MNL LO: Analyze the concept of cognition and its application to nursing care.

5) A client with dementia is prescribed donepezil (Aricept). Which information about the medication should the nurse consider when teaching this client?
A) It shortens the early stages of Alzheimer disease.
B) It is an acetylcholinesterase inhibitor that has a modest effect in slowing the progression of Alzheimer disease.
C) It is an anticholinergic and has been known to eradicate some of the symptoms associated with Alzheimer disease.
D) It should be taken on an empty stomach.
Answer: B
Explanation: A) Donepezil does not shorten the early stages of Alzheimer disease.
B) Acetylcholinesterase inhibitors reduce acetylcholine breakdown and have a modest effect in slowing an individual's rate of cognitive decline in Alzheimer disease.
C) Symptoms are not eradicated, but progression is slowed. These medications should be taken on a full stomach, and antiemetic medications may also be needed.
D) This medication should be taken on a full stomach.
Page Ref: 1776-1777
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 23.4. Explain measures to promote optimal cognition.
MNL LO: Analyze the concept of cognition and its application to nursing care.

6) Which cognitive development theory proposes that all children progress through the same stages of development?
A) Piaget
B) Vygotsky
C) Information-processing
D) Erickson
Answer: A
Explanation: A) Piaget's cognitive development theory proposes that all children progress through the same stages of development.
B) Vygotsky's theory discards the idea that all children progress through the same stages of development. Instead, Vygotsky theorized that skill development is influenced by the child's environment and culture.
C) The information-processing theory views the mind as a computer that is always changing and evolving and takes in information, operates on it, and converts it to answers. Erickson's theory is not a cognitive development theory, but rather is a behavioral development theory.
D) Erickson's theory is not a cognitive development theory, but rather is a behavioral development theory.
Page Ref: 1769
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 23.1. Analyze the physiology of normal cognition.
MNL LO: Analyze the concept of cognition and its application to nursing care.

7) Which statement is true regarding the aging process and cognition?
A) Generally, older adults' short-term memory changes significantly.
B) Generally, many older adults have increased difficulty finding and rapidly listing words.
C) The ability to use and understand word combinations declines steadily with age.
D) The ability to acquire practical information declines steadily with age.
Answer: B
Explanation: A) In general, older adults' short-term memory remains intact.
B) Older adults typically have more difficulty with cognitive functions, such as word retrieval and episodic memory.
C) The ability to use and understand word combinations remains intact.
D) Most older adults are able to acquire practical information until their death.
Page Ref: 1771
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 23.2. Differentiate alterations in cognition.
MNL LO: Analyze the concept of cognition and its application to nursing care.

8) The nurse is caring for a client with perceptual disturbances who is becoming agitated. Which action should the nurse take first?
A) Distract client by taking into the dayroom to watch television with other clients.
B) Administer medications to sedate client before violent behaviors occur.
C) Request client to go back to room and dim lights.
D) Do nothing, as this is a normal manifestation of disturbed cognition.
Answer: C
Explanation: A) Taking the client into the dayroom to watch television with others may overstimulate the client, further increasing agitation, which may increase risk of violence toward others.
B) The use of pharmacologic restraints should be avoided.
C) The nurse that observes a client demonstrating visual disturbances and/or psychotic behaviors should intervene by decreasing the environmental stimulus.
D) If overstimulated, the client with visual disturbances or psychosis may display agitation.
Page Ref: 1754
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 23.6. Analyze independent interventions nurses can implement for patients with alterations in cognition.
MNL LO: Analyze the concept of cognition and its application to nursing care.

9) The nurse walks into the client room, and the client is confused and disoriented. Ten minutes prior, the client was oriented to person, place, and time and was not confused. Which nursing action is priority?

A) Position client in supine position

B) Assess vital signs and pulse oxygenation

C) Ambulate client to encourage lung expansion

D) Obtain urine for urinalysis

Answer: B

Explanation: A) There is no reason to position the client supine.

B) Decreased O_2 reaching the brain may lead to cognitive impairment, coma, and death. A client demonstrating a rapid onset of confusion and disorientation will need to have vital signs, pulse oximetry, and airway assessed for signs of impaired perfusion.

C) Ambulating a client demonstrating these symptoms would be premature and could cause additional harm if there is impaired oxygen perfusion.

D) Although urinary tract infections may cause acute mental status changes, the priority action would not be to obtain urine for a urinalysis.

Page Ref: 1762

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 23.6. Analyze independent interventions nurses can implement for patients with alterations in cognition.

MNL LO: Analyze the concept of cognition and its application to nursing care.

10) A 7-year-old child presents to the primary care office for a routine physical. Which question should the nurse include during the interview to identify the need for education related to preventing potential cognitive disorders?
A) "Do you wear a helmet when you ride a bicycle or skateboard?"
B) "How many times per day do you brush your teeth?"
C) "How are your grades in school?"
D) "How many hours per day do you watch television?"
Answer: A
Explanation: A) Nurses accomplish prevention and protective measures through teaching and providing anticipatory guidance. An example of an independent intervention is ensuring that children wear their bicycle helmets to aid in prevention of head trauma that could lead to cognitive abnormalities.
B) Brushing teeth is irrelevant to impaired cognition.
C) Asking about school grades is irrelevant to impaired cognition.
D) Time watching television is irrelevant to impaired cognition.
Page Ref: 1762
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 23.8. Differentiate considerations related to the assessment and care of patients with alterations in cognition throughout the lifespan.
MNL LO: Analyze the concept of cognition and its application to nursing care.

Exemplar 23.A Alzheimer Disease

1) The spouse of a client with Alzheimer disease does not understand why the client developed the disorder because no one else in the family has the health problem. Which response by the nurse is appropriate?
A) "Alzheimer disease develops because of smoking and alcohol intake."
B) "Someone in your family must not have been correctly diagnosed with the disorder."
C) "Alzheimer disease does not have the same course in every individual."
D) "There are genetic and environmental factors in the development of Alzheimer disease."
Answer: D
Explanation: A) Alzheimer disease is not directly linked to smoking and alcohol intake.
B) It is inappropriate to assume that other family members had the disorder but were misdiagnosed.
C) Alzheimer disease has a predictable course with distinct phases or stages.
D) Researchers are not sure why most cases of Alzheimer disease (AD) arise, although a variety of genetic and environmental factors appear to be involved.
Page Ref: 1773
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Describe the pathophysiology of Alzheimer disease.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

2) An adult child brings a parent in to be evaluated and is told the client has Alzheimer disease. The adult child asks the nurse if he is also at risk for the disease. Which risk factors should the nurse include when responding? **Select all that apply.**

A) Genetic predisposition
B) Age
C) History of hypertension
D) Hearing deficits
E) Gender

Answer: A, B, C, E

Explanation: A) Individuals with a family history of AD are more likely to develop the disease, even in the absence of known genetic factors that predict or increase the risk of the disease.

B) The most prominent risk factor for Alzheimer disease is advancing age.

C) Research has identified risk factors of AD to include cardiovascular risks such as diabetes, mid-life obesity, mid-life hypertension, and hyperlipidemia.

D) There is no indication that hearing deficits play a role in the development of Alzheimer disease.

E) AD is almost three times more common in women than men.

Page Ref: 1774

Cognitive Level: Applying

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Compare the risk factors and prevention of Alzheimer disease.

MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

3) A client diagnosed with Alzheimer disease becomes agitated during an activity involving simultaneous music playing and a craft project. The client starts shouting, "No! No! No!" and runs from the room. Which action by the nurse is the most appropriate?
A) Administer a prn anti-anxiety medication.
B) Restrict participation in any group activities.
C) Call security and prepare physical restraints.
D) Reassure the client and then redirect to a quiet area.
Answer: D
Explanation: A) Use of pharmacologic restraints should be avoided.
B) Once the client is less agitated, the client can be directed to a less stimulating activity.
C) Use of physical restraints should be avoided.
D) Environmental stimuli should be kept at a minimum for clients with dementia. A quiet environment will prevent sensory overload.
Page Ref: 1779-1780
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with Alzheimer disease.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

4) The nurse is preparing an educational program for clients in a long-term care facility regarding protective factors for Alzheimer disease (AD). Which information should the nurse include? **Select all that apply.**
A) Becoming involved in activities such as reading that keep the mind active
B) Incorporate a high-calorie, high-carbohydrate diet to decrease formation of amyloid plaques
C) Remain socially active
D) Including modest exercise into daily regimen
E) Begin drinking a glass of wine each night before bed
Answer: A, C, D
Explanation: A) Evidence demonstrates that cognitive activities such as reading, completing puzzles, and learning new information or tasks build cognitive resilience and protect against cognitive decline.
B) There is some evidence to suggest that the heart-healthy diets that include antioxidant- and polyphenol-rich foods such as tea, cocoa, grapes, and colorful fruits and vegetables may interrupt formation of amyloid plaques and prevent AD.
C) Social engagement may improve cognitive function and have some protective effects against AD.
D) Modest levels of exercise have been demonstrated to improve cognitive function.
E) Moderate alcohol consumption may be protective against AD. However, evidence is insufficient to suggest that individuals who do not already drink should start drinking.
Page Ref: 1774
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with Alzheimer disease.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

5) The nurse is planning care for a client with stage 1 Alzheimer disease. Which problems are the priority for the client and family?
A) Cognitive impairment and caregiver burden
B) Risk of injury and undernutrition
C) Inability to perform self-care and fear
D) Compromised physical mobility and wandering
Answer: A
Explanation: A) Appropriate problems may depend on the stage of Alzheimer disease (AD). Cognitive impairment would be appropriate for stage 1 AD. Caregiver burden would be appropriate for any stage of AD.
B) The client is in stage 1 of AD. The risk for injury and undernutrition would not be problems at this time.
C) The client is in stage 1 of AD. The inability to perform self-care and fear would not be problems at this time.
D) The client is in stage 1 of AD. Compromised physical mobility and wandering would not be problems at this time.
Page Ref: 1778-1779
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with Alzheimer disease.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

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6) The nurse is planning care to address safety needs for an older adult client who has recently been diagnosed with early Alzheimer disease. Which interventions are appropriate to address safety needs? **Select all that apply.**

A) Use of a restraint belt at night to prevent wandering behaviors
B) Check shoes for fit and support.
C) Contact the department of motor vehicles to have the client's license suspended.
D) Keep all familiar objects in the home.
E) Remove throw rugs and electrical cords.

Answer: B, E

Explanation: A) The use of physical and pharmacologic restraints should be avoided.
B) All older clients, including those with Alzheimer disease (AD), are at increased risk for injuries such as falls. Shoes should fit and be supportive.
C) In early stages of dementia, clients with Alzheimer disease may continue to drive.
D) Simplifying the home environment while keeping familiar furniture in the same space will reduce confusion and promote safety.
E) Rugs and cords should be removed to prevent falls.

Page Ref: 1779-1780
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with Alzheimer disease.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

7) The nurse is planning care for a client who is experiencing stage 1 Alzheimer disease. Which intervention will best promote cognitive function?
A) Ensure there is background music or sound from the television.
B) Dim the lights during waking hours.
C) Maintain a daily routine.
D) Keep social interaction to a minimum.
Answer: C
Explanation: A) The client typically is better oriented when it is quiet.
B) It is important keep the room lit during waking hours; the lights should not be dimmed during this time.
C) The client with dementia benefits from a routine schedule of activities, including meal times.
D) Social interactions should be promoted and supported.
Page Ref: 1775
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with Alzheimer disease.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

8) The nurse is educating the family and client, who was recently diagnosed with Alzheimer disease (AD), regarding long-term care placement. For which reason should the nurse provide the family with this information at this time?
A) It often takes 6 to 12 months for an individual with AD to establish a successful transfer to a facility, and this will allow adequate time.
B) It's better to address the issue of placement now instead of later.
C) Early introduction to long-term options will allow the client and family time to make a more informed decision.
D) Long-term care placement is inevitable with this diagnosis.
Answer: C
Explanation: A) There is no plan to transfer the client at this time; adjustment would occur after the transfer.
B) Nurses will need to provide reinforced education and referrals throughout the disease process, not just during the initial hospitalization.
C) Providing the information early in the disease process allows the family to make an informed choice.
D) Although placement in a long-term care facility is not going to be the fate of all individuals with Alzheimer disease, it is a common one.
Page Ref: 1780
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Differentiate care of patients with Alzheimer disease across the lifespan.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

9) A client is diagnosed as having stage 1 Alzheimer disease. Which goals would the nurse identify for the client and family at this time? **Select all that apply.**
A) Resolving grief over the diagnosis
B) Deciding on the desired treatment and selecting a healthcare proxy; sharing the treatment decision with the healthcare proxy
C) Beginning cognitive-enhancing medication, such as donepezil (Aricept)
D) Setting up a protective physical environment–such as removing throw rugs
E) Making provisions for assistance with activities of daily living (ADLs)
Answer: A, B, C, D
Explanation: A) Grieving over the diagnosis and loss of functioning and mental abilities will be an ongoing process for the client and the family members and is, therefore, a goal.
B) While the client is still cognizant, it is important that the client and family discuss the desired treatment and designate a healthcare proxy to carry out the client's wishes regarding the treatment.
C) Clients with early Alzheimer disease should start the cholinesterase inhibitor medication as soon as possible to extend the early stage of the disease.
D) During this time period, the home environment should be modified to balance safety with client autonomy.
E) Clients in stage 1 of Alzheimer disease continue to be proficient with ADLs and do not require assistance.
Page Ref: 1775
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with Alzheimer disease.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

10) A client with Alzheimer disease is scheduled to attend occupational therapy three times a week. For which reason should the client attend this type of therapy?
A) Improve language deficits
B) Improve muscle tone
C) Ability to perform activities of daily living
D) Improve access to community organizations
Answer: C
Explanation: A) Individuals who are starting to experience language deficits may be able to slow this decline by working with a speech therapist.
B) Physical therapy can help individuals improve their muscle tone, maintain coordination, and maintain their range of motion.
C) Occupational therapy helps the client maintain the ability to perform many activities of daily living.
D) Access to community organizations is facilitated through the use of social workers.
Page Ref: 1775
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with Alzheimer disease.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

11) The nurse plans a class about Alzheimer disease for a caregiver support group. Which should the nurse include when teaching this class of caregivers? **Select all that apply.**
A) Glutamatergic inhibitors are the most common class of drugs for treating Alzheimer disease.
B) Alzheimer disease accounts for about 60% to 80% of all dementias.
C) Genetic, environmental, and lifestyle factors are involved in the development.
D) Depression and aggressive behavior are common with the disease.
E) Memory difficulties are an early symptom of the disease.
Answer: B, C, D, E
Explanation: A) The acetylcholinesterase inhibitors, not the glutamatergic inhibitors, are the most widely used class of drugs for treating the disease.
B) Alzheimer disease accounts for about 60% to 80% of all dementias.
C) It is suspected that genetic, environmental, and lifestyle factors contribute to the development of AD.
D) Depression and aggressive behavior are common symptoms of the disease.
E) Memory difficulties are an early symptom of Alzheimer disease.
Page Ref: 1772-1774
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Identify the clinical manifestations of Alzheimer disease.

MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

12) The nurse is reviewing pharmacologic treatments with a caregiver of an individual with Alzheimer disease. Which statement indicates that teaching has been effective?
A) "There are effective drugs, but they cannot be used over a long period."
B) "There aren't any drugs that are effective in treating this disease."
C) "The earlier the drugs are started, the greater the likelihood they will have benefits."
D) "There are drugs that can control symptoms for many years."
Answer: C
Explanation: A) The drugs for treatment of Alzheimer disease are no more dangerous than other drugs used for a long period of time.
B) Current medications will only decrease symptoms for a short period of time.
C) The earlier the medications are started, the greater the effect they will have on the symptoms of Alzheimer disease.
D) Drugs will not control symptoms for many years.
Page Ref: 1776
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with Alzheimer disease.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

13) The nurse visits a client with stage 2 Alzheimer disease who lives at home with a spouse. Which action by the nurse enhances the spouse's ability to meet the needs of the client?
A) Encouraging the caregiver to obtain rest and eat a healthy diet
B) Providing the client a list of daily activities to complete
C) Making arrangements for the client to visit the local senior citizen center in the afternoon
D) Finding placement in a long-term care facility
Answer: A
Explanation: A) Stage 2 clients are generally more confused, can demonstrate repetitive behavior, are less able to make simple decisions and to adapt to environmental changes, and are often unable to carry out activities of daily living. The spouse needs opportunities to obtain the sleep and nutrition necessary to preserve personal health.
B) A list of activities would be better suited for the client in stage 1.
C) Because the stage 2 client does not adapt well to changes in the environment, it would be best to have someone come into the home, rather than to have the client go out. An outing would be better suited for the client in stage 1.
D) Recommending placement in long-term care might be premature and is not up to the nurse.
Page Ref: 1777
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with Alzheimer disease.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

14) The nurse is caring for a client with Alzheimer disease (AD) who has receptive aphasia. Which area of the brain is likely damaged from AD?
A) Temporal lobe
B) Limbic system
C) Frontal lobe
D) Occipital lobe
Answer: A
Explanation: A) Damage to the client's temporal lobe manifests as impaired memory, difficulty learning new things, and receptive aphasia.
B) Damage to the limbic system manifests as loss of memory, fluctuating emotions, depression, and difficulty learning new information.
C) Damage to the frontal lobe manifests as problems with intentional movement, fluctuating emotions, and loss of the ability to walk. Frontal lobe damage also causes loss of the ability to talk and the ability to swallow.
D) Damage to the occipital lobe results in loss of reading comprehension and hallucinations.
Page Ref: 1773
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Describe the etiology of Alzheimer disease.

MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

15) Which statements are true regarding the pathophysiology and etiology of Alzheimer disease? **Select all that apply.**

A) Damage to the limbic system results in speech decline and slowed movements.
B) Familial Alzheimer disease (FAD) is also called delayed-onset Alzheimer disease.
C) Sporadic Alzheimer disease usually manifests before age 65.
D) Sporadic Alzheimer disease is more common than familial Alzheimer disease.
E) In Alzheimer disease, neuronal cells die in a characteristic order.

Answer: D, E

Explanation: A) Damage to the limbic system from AD results in memory loss and emotional problems.

B) Familial AD has a strong inherited component and is also called early-onset AD because it usually manifests before age 65.

C) Sporadic AD shows no clear pattern of inheritance, although genetic factors may be involved.

D) Because it typically develops after age 65, sporadic AD is sometimes referred to as late-onset AD.

E) In Alzheimer disease, the neuronal cells die in a characteristic order, beginning with neurons in the limbic system, including the hippocampus.

Page Ref: 1772

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Describe the pathophysiology of Alzheimer disease.

MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

16) The nurse is assessing a client diagnosed with Alzheimer disease (AD) in which the family reports that the client recently lost the ability to live independently and is unable to perform certain activities of daily living (ADLs) such as selecting appropriate clothing or preparing meals. The family's report indicates that the client has progressed to which stage of AD?
A) Stage 1
B) Stage 2
C) Stage 3
D) Stage 4
Answer: B
Explanation: A) A client in stage 1 (mild cognitive impairment) is able to maintain living independently, but the client's memory lapses are apparent to others.
B) This client is in stage 2 (moderate AD) because the client has lost the ability to live independently. In this stage, the client may be unable to choose appropriate clothing or prepare food and is at increased risk of someone taking advantage of him or her because of loss of cognition and lack of safety awareness.
C) In stage 3 (severe AD), individuals become unable to perform even basic activities of daily living (ADLs).
D) AD is described in terms of three stages: stage 1 (early), stage 2 (moderate), and stage 3 (severe). There is no stage 4 of AD.
Page Ref: 1775
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Identify the clinical manifestations of Alzheimer disease.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

17) The nurse is educating a client who is diagnosed with stage 1 Alzheimer disease (AD) and the client's spouse. Which suggestion best promotes maintaining functional ability at this stage?
A) Obtain round-the-clock care at home
B) Prepare liquid nutrition
C) Assist client with ADLs
D) Begin making "to-do" lists and use of a calendar
Answer: D
Explanation: A) Around the clock care at home is more appropriate for a client with stage 3 AD.
B) Liquid nutrition is more appropriate for a client with stage 3 AD.
C) Assisting with ADLs is more appropriate for a client with stage 2 or stage 3 AD.
D) Use of cuing devices such as to-do lists, calendars, written schedules, and verbal reminders can aid in maintaining client's highest level of functioning in stage 1 AD.
Page Ref: 1775
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with Alzheimer disease.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

18) A client presents with signs and symptoms of early Alzheimer disease. Which finding would be used to confirm this client's diagnosis?
A) Abnormal CT scan findings of plaques and tangles in the brain
B) Client history and physical examination
C) Positive blood tests for beta-amyloid and tau proteins
D) Blood test for amyloid plaques and neurofibrillary tangles
Answer: B
Explanation: A) The diagnosis of Alzheimer disease is based on the client history and physical examination. There is currently no one test or procedure that makes the diagnosis of Alzheimer disease. As AD progresses and more neurons die, two characteristic abnormalities develop in the brains of affected individuals. Abnormal CT scan findings of plaques and tangles in the brain are found at autopsy.
B) The diagnosis of Alzheimer disease is based on the client history and physical examination.
C) There is currently no blood test to diagnose AD.
D) There is currently no blood test to diagnose AD.
Page Ref: 1774, 1776
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with Alzheimer disease.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

19) The nurse is teaching the family of a client who has just been diagnosed with dementia. The family asks if there are treatments available that will cure the client. Which response should the nurse make?

A) "There are no treatments that will cure dementia at this time."
B) "Treatments to cure dementia include the use of vitamin E."
C) "Treatments to cure dementia involve hormone replacement therapy."
D) "There are no treatments that can slow the progression of the disease."

Answer: A

Explanation: A) Currently no treatment has been found to reverse or stop the pathologic process in progressive dementia.
B) Studies on the use of dietary supplements such as antioxidant vitamins are inconclusive.
C) Hormone replacement therapy is not used to cure dementia.
D) There are two classes of medications used to slow the progression of the disease.

Page Ref: 1776

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with Alzheimer disease.

MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

20) Damage to which region of the brain may result in loss of recent memory?
A) Neuron
B) Hippocampus
C) Cerebrum
D) Neurotransmitter
Answer: B
Explanation: A) A neuron carries and processes information within the nervous system.
B) The structure that plays a role in memory is the hippocampus, located in the limbic system of the brain.
C) The cerebrum is the largest region of the brain.
D) A neurotransmitter is a chemical messenger within the nervous system.
Page Ref: 1772
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 23.A. Analyze Alzheimer disease as it relates to cognition. Describe the pathophysiology of Alzheimer disease.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with Alzheimer disease.

Exemplar 23.B Delirium

1) An older adult client complains of periods of confusion and forgetfulness but reports clear thought process at most times of the day. Which response should the nurse make?
A) "Are you having trouble hearing?"
B) "You probably have nothing to worry about. It's most likely stress-related."
C) "Everybody has a few problems with memory as they get older."
D) "You should probably have an MRI of your brain."
Answer: A
Explanation: A) People who cannot hear or see well often appear confused. The nurse should assess whether the client is having difficulty with hearing prior to moving on in the assessment process.
B) The nurse has no way of knowing if the client's symptoms are caused by stress.
C) Memory loss with confusion and forgetfulness is not part of the normal aging process.
D) The nurse needs to explore further before an expensive diagnostic study is considered. It would be beyond the scope of practice for the nurse to recommend this testing.
Page Ref: 1783
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 23.B. Analyze delirium as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with delirium.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with delirium.

2) An older adult client with no history of cognitive impairment is suddenly showing signs of increased confusion and possible delirium. Which health problem should the nurse suspect is causing this client's confusion?
A) Cataracts
B) Hypertension
C) Urinary tract infection
D) Lower back strain
Answer: C
Explanation: A) Cataracts are not conditions that are known to cause signs of confusion in older adults.
B) Hypertension is not known to cause signs of confusion in older adults.
C) Delirium is often the most prominent manifestation of conditions such as dehydration, respiratory tract infections, urinary tract infections, and urinary retention, and adverse drug events may occur in the absence of symptoms such as fever or discomfort.
D) Lower back strain is not known to cause signs of confusion in older adults.
Page Ref: 1785
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 23.B. Analyze delirium as it relates to cognition. Identify the clinical manifestations of delirium.

MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with delirium.

3) The nurse is caring for a client who becomes confused and agitated every evening. Medical reasons for the change in mental status have been ruled out. The nurse correctly communicates to the other healthcare team members that the client is experiencing which phenomenon?

A) Delirium
B) Sundowning
C) Aphasia
D) Chronic psychosis

Answer: B

Explanation: A) Delirium is a rapid-onset type of confusion.

B) Sundowning is understood as confusion that intensifies in the evening or at bedtime. The client can become increasingly agitated, disoriented, or even aggressive/paranoid or impulsive and emotional later in the day and at night.

C) Aphasia is the inability to use or understand language.

D) Psychosis is a mental disorder, and this client is not exhibiting signs of psychosis.

Page Ref: 1784

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 23.B. Analyze delirium as it relates to cognition. Describe the pathophysiology of delirium.

MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with delirium.

4) The family of an older adult client is informed that the client has delirium. Which statement indicates that the family understands the diagnosis?
A) "It's sad that dad is getting dementia."
B) "The changes in his behavior came on so quickly, which may be the result of an underlying medical condition."
C) "Our father is going to need long-term psychiatric care."
D) "Confusion is normal in older adults, and it goes away on its own."
Answer: B
Explanation: A) Impairments in short-term memory are more indicative of dementia.
B) Delirium is characterized by a rapid and abrupt onset of symptoms and caused by an underlying medical condition. Once the medical condition is treated, the delirium resolves.
C) The fact that he had been independent has no bearing on his current symptoms.
D) Although delirium is more common in older individuals, aging is not a cause of delirium.
Page Ref: 1784
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 23.B. Analyze delirium as it relates to cognition. Identify the clinical manifestations of delirium.

MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with delirium.

5) An older adult client, hospitalized post-surgery, wakes up in the middle of the night very confused. The nurse reorients the client to the surroundings and gets the client to return to sleep. Which reason should the nurse consider as a source for the client's confusion?

A) A hypnotic/sedative, taken at bedtime for sleep
B) The client's age
C) The death of the client's husband last month
D) History of cardiac disease

Answer: A

Explanation: A) Certain medications, such as hypnotics/sedatives, anxiolytics, antidepressants, anti-Parkinson drugs, anticonvulsants, or antispasmodics, also increase symptoms of delirium. Therefore, the client's medication must be reviewed to determine the effects of drugs and cognitive changes.

B) Age alone does not cause confusion.

C) Although loss of a loved one may result in depression, it is unlikely to be the source of confusion.

D) Cardiac disease alone would not cause confusion.

Page Ref: 1783

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 23.B. Analyze delirium as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with delirium.

MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with delirium.

6) A school-age client is hospitalized with encephalitis and is experiencing delirium. Which intervention promotes a therapeutic environment for this child and family?
A) Making sure the parents perform all treatments for their child
B) Encouraging the family to remain at the bedside with the client
C) Making sure the child comes back for the follow-up appointment
D) Providing written instructions before discharge
Answer: B
Explanation: A) Having parents perform treatment for the child is a part of discharge planning.
B) Besides the prevention and management of the underlying medical condition, the presence of parents and family members has been found to reduce the incidence of delirium.
C) Reminders to attend follow-up appointments is a part of discharge planning.
D) Providing written instructions is a part of discharge planning.
Page Ref: 1785, 1787
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 23.B. Analyze delirium as it relates to cognition. Differentiate care of patients with delirium across the lifespan.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with delirium.

7) A hospitalized older adult client suddenly does not recognize an adult daughter and states, "Why hasn't my wife come to see me?" The client's spouse has been deceased for 5 years. Prior to the hospitalization, the client was oriented to person, place, time, and reality. Which nursing problems would be appropriate for this client? **Select all that apply.**

A) Lack of knowledge about delirium
B) Anxiety
C) Confusion
D) Risk for injury
E) Impaired communication

Answer: C, D

Explanation: A) The scenario does not indicate the client lacks knowledge about delirium.
B) There is no evidence the client is experiencing anxiety.
C) The client is experiencing confusion.
D) The client is at risk for injury according to the scenario presented.
E) There is no evidence that the client has impaired communication.

Page Ref: 1786

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 23.B. Analyze delirium as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with delirium.

MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with delirium.

8) The staff on a care area that has a high percentage of clients with confusion attends an educational program on delirium management. Which statement, made by a staff nurse, indicates that teaching has been effective?
A) "It is important to provide education for family members as needed."
B) "Sensory deprivation and overstimulation can worsen the symptoms the client exhibits."
C) "Decreasing all stimulation in the client's room is essential."
D) "The family should involve the client in all conversations and interactions involving care."
Answer: B
Explanation: A) The family should be instructed about delirium management as often as necessary and not just when needed.
B) The structure of the client's environment should support cognitive functions. Aids for hearing or vision are necessary to prevent sensory loss or distortion.
C) Familiar objects from home, such as slippers, robe, and photographs, may help with orientation. Easily read clocks, orientation boards, and a structured routine that includes physical activity and socialization without sensory overload will also help with orientation.
D) Clients with delirium can exhibit hyperactivity when overstimulated.
Page Ref: 1784
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 23.B. Analyze delirium as it relates to cognition. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with delirium.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with delirium.

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9) The nurse is explaining the difference between delirium and dementia to a family member of a client with confusion. Which statement is appropriate for the nurse to include?
A) "The cause of delirium is always unknown."
B) "Dementia develops suddenly."
C) "Delirium is a serious but common occurrence in older adult clients who are hospitalized."
D) "Delirium is often confused with depression in older adult clients."
Answer: C
Explanation: A) The cause of delirium can often be determined, and removal of the cause will usually result in complete recovery.
B) Delirium is an acute rapid-onset condition with an etiology that can usually be traced to a known cause.
C) Hospitalized clients are much more likely to experience delirium because of the presence of predisposing illnesses, exposure to multiple medical interventions that may contribute to cognitive changes, and being in an environment that is unfamiliar, stimulating, and not conducive to maintaining normal diurnal rhythms.
D) The symptoms of delirium are not similar to those of depression.
Page Ref: 1783
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 23.B. Analyze delirium as it relates to cognition. Identify the clinical manifestations of delirium.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with delirium.

10) The nurse identifies the problem risk for injury for a client who is disoriented. Which outcome should the nurse identify for this client's care?
A) The client does not sustain injuries during wanderings.
B) The client remains continent of bowel and urine.
C) The client receives culturally appropriate care.
D) The client sleeps through the night and stays awake most of the day.
Answer: A
Explanation: A) The client "does not sustain injury during wanderings" is a goal because it relates to the risk for injury.
B) Maintaining continence does not relate to the problem of risk for injury.
C) Receiving culturally appropriate care is a nursing goal.
D) Sleeping through the night and staying awake during the day does not apply to the problem of risk for injury.
Page Ref: 1786
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.A.5. Describe factors that create a culture of safety (such as, open communication strategies and organizational error reporting systems). | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 23.B. Analyze delirium as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with delirium.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with delirium.

11) The nurse is caring for a school-age client who was admitted with pneumonia and high fever. The parents are very upset because the child is now unable to recognize them. Which statements should the nurse include while educating the parents on their child's symptoms? **Select all that apply.**

A) Instruct the family to reorient the client to time and place as much as possible.
B) Encourage the family remain at the bedside as much as possible.
C) Explain that high fevers can cause delirium.
D) Reassure that the confusion will not last very long.
E) Teach the family how to care for the child upon discharge.

Answer: A, B, C

Explanation: A) Reorienting to time and place will help reduce confusion.

B) The presence of parents and family members has been found to reduce the incidence of delirium as well as decrease family stress.

C) The nurse will want to explain that any febrile illness may cause symptoms of delirium and that this symptom will abate when the temperature returns to normal.

D) Telling the family the confusion will not last long is not helping them to understand the nature of the symptom.

E) Teaching the family how to care for the child during the hospitalization or upon discharge will not necessarily decrease their anxiety.

Page Ref: 1787

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 23.B. Analyze delirium as it relates to cognition. Differentiate care of patients with delirium across the lifespan.

MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with delirium.

12) Which statement is true regarding the Confusion Assessment Method (CAM)?
A) It consists of five parts and is a lengthy test.
B) It measures the severity of the client's delirium.
C) It is also effective in screening for depression.
D) It is effective in screening for cognitive impairment and reversible confusion.
Answer: D
Explanation: A) The Confusion Assessment Method (CAM) consists of two parts; the first part screens for cognitive impairment and the second part screens for reversible confusion.
B) It does not measure the severity of the client's delirium.
C) It does not screen for depression.
D) The Confusion Assessment Method (CAM) is a tool the nurse can use to differentiate between delirium and dementia.
Page Ref: 1786
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.B.5. Assess levels of physical and emotional comfort. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 23.B. Analyze delirium as it relates to cognition. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with delirium.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with delirium.

13) The nurse manager is educating a group of staff nurses on recognizing the differences between confusion and delirium. Which statements should be included in the teaching? **Select all that apply.**

A) "Delirium is seen only in older adults."
B) "Delirium is a reversible condition while dementia is not."
C) "Older adults are at higher risk for developing delirium."
D) "Younger adult females are at higher risk for developing delirium."
E) "Adolescents are more prone to developing delirium than young children."

Answer: B, C

Explanation: A) Delirium can occur at any age.
B) Delirium is a reversible condition caused by an acute problem, such as infection, and can occur at any age. Dementia is a cognitive decline generally associated with an aging adult.
C) Older adults are at higher risk for developing delirium.
D) Younger adult females are not at higher risk for developing delirium.
E) Young children are at greater risk for developing delirium than adolescents because children's bodies are less equipped to cope with insults such as fever, infection, and toxin exposure.

Page Ref: 1783
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 23.B. Analyze delirium as it relates to cognition. Describe the pathophysiology of delirium.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with delirium.

Exemplar 23.C Schizophrenia

1) The nurse is caring for a client with schizophrenia whose symptoms of psychosis have resolved. The client's family complains that the client's hygiene remains poor and lacks motivation and initiative. Which conclusion by the nurse is most appropriate?
A) The client is experiencing negative symptoms.
B) The client is experiencing disordered thinking.
C) The client was misdiagnosed.
D) The client is most likely hearing voices.
Answer: A
Explanation: A) Negative symptoms are those that subtract from normal behavior. These symptoms include a lack of interest, motivation, responsiveness, pleasure in daily activities, or the ability to care for self.
B) Positive symptoms include hallucinations, delusions, and a disorganized thought or speech pattern.
C) There isn't any evidence to support that the client was misdiagnosed.
D) There isn't any evidence to support that the client is hearing voices.
Page Ref: 1790
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 23.C. Analyze schizophrenia as it relates to cognition. Identify the clinical manifestations of schizophrenia.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with schizophrenia.

2) The nurse is educating an adolescent client with schizophrenia on predisposing risk factors. Which significant risk factor should the nurse include in the teaching?
A) Summer birthdate
B) Parents recently divorced
C) Early life adversity
D) Lives in rural setting
Answer: C
Explanation: A) Time of birth is not identified as a risk factor for schizophrenia.
B) Parents' divorce is not identified as a risk factor for schizophrenia.
C) Early life adversity (including exposure to chronic and acute stressors such as poverty, violence, and trauma) has been implicated in schizophrenia.
D) Living in a rural area is not a risk factor for schizophrenia.
Page Ref: 1789
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 23.C. Analyze schizophrenia as it relates to cognition. Compare the risk factors and prevention of schizophrenia.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with schizophrenia.

3) The nurse is teaching techniques to improve communication skills to a family with a member with schizophrenia. Which techniques should be included? **Select all that apply.**
A) Use active listening.
B) Making positive, specific requests for change.
C) Use "I" language to express feelings.
D) Encourage client to communicate with only family.
E) Use "you" statements to point out negative behavior.
Answer: A, B, C
Explanation: A) Engage in active listening (e.g., asking questions and nodding in agreement when another person speaks).
B) Make positive, specific requests for change that are linked to emotions (e.g., "I would really like it if you could play a game with us tonight.").
C) Use "I" language to express positive feelings (e.g., "I am happy when you decide to sit down for dinner with us.").
D) Increasing communication in a safe setting with family and friends helps to stimulate both self-confidence and the fostering of important relationships.
E) Express negative feelings with "I" rather than "you" language (e.g., saying "I'm worried that you may not be getting enough sleep." instead of "You never get enough sleep at night.").
Page Ref: 1801
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 23.C. Analyze schizophrenia as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with schizophrenia.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with schizophrenia.

4) The nurse is caring for a client who is experiencing auditory hallucinations. Which problem is the priority for this client?
A) Disturbed thought processes
B) Inadequate coping skills
C) Impaired verbal communication
D) Risk of injury
Answer: D
Explanation: A) Although the client has impaired thought processes, this is not the priority problem at this time.
B) Inadequate coping skills is not the priority for this client.
C) Impaired verbal communication is not the priority for this client.
D) Maintaining a safe environment is the priority diagnosis. When hallucinating or interpreting others' actions and statements from the standpoint of delusions, the client may believe themselves to be in danger, regardless of whether there is a factual basis for the fear. Under such circumstances, both the client and perceived aggressors may be at risk for injury.
Page Ref: 1800
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 23.C. Analyze schizophrenia as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with schizophrenia.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with schizophrenia.

5) The nurse is providing education related to improving family dynamics for the family of an adolescent diagnosed with schizophrenia. Which topics should be included in the teaching? **Select all that apply.**
A) Adopt healthier behaviors
B) Identify coping mechanisms
C) Discuss childhood memories
D) Prevent future episodes
E) Improve communication
Answer: A, B, E
Explanation: A) Adopting healthier behaviors helps improve coping skills.
B) The family should be assisted in identifying healthy coping skills.
C) Discussing childhood memories is irrelevant to treatment.
D) The family may not be able to prevent future psychologic episodes.
E) Improving communication is a method to improve coping and develop new and effective strategies.
Page Ref: 1800-1801
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 23.C. Analyze schizophrenia as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with schizophrenia.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with schizophrenia.

6) The healthcare provider prescribes aripiprazole (Abilify) for the client with schizophrenia. Which outcome is the priority for the client?
A) The client will report a decrease in auditory hallucinations.
B) The client will report symptoms of restlessness.
C) The client will consume adequate fluids and a high-fiber diet.
D) The client will adhere to the medication regime.
Answer: D
Explanation: A) A decrease in auditory hallucinations is an expected effect of aripiprazole (Abilify), but this is not the priority outcome.
B) The symptom of restlessness is known as akathisia. This would be important to report, but it is not the priority outcome.
C) Adequate fluids and fiber will decrease the side effect of constipation, but this is not the priority outcome.
D) Medication compliance is a priority for clients with schizophrenia. Relapse of symptoms will occur without the medications.
Page Ref: 1796
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 23.C. Analyze schizophrenia as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with schizophrenia.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with schizophrenia.

7) The nurse is conducting a group therapy session for clients diagnosed with schizophrenia. Which intervention addresses the cognitive deficits associated with this disorder?
A) Have clients wear name tags.
B) Provide a highly stimulating environment.
C) Encourage open-ended activities.
D) Use humor.
Answer: A
Explanation: A) Name tags assist clients to remember other group members' names and may foster social interaction.
B) Decreased stimuli would address deficits in focus and attention.
C) Structured activities and cues are required to address lack of spontaneity in speech.
D) Individuals with schizophrenia may have concrete thinking and may not respond well to humor.
Page Ref: 1790
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 23.C. Analyze schizophrenia as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with schizophrenia.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with schizophrenia.

8) The client is receiving risperidone (Risperdal) for the treatment of schizophrenia. Which client statement indicates the medication is effectively treating the positive symptoms of schizophrenia?
A) "I promise not to skip breakfast anymore."
B) "I am not hearing the voices anymore."
C) "I will start going to group therapy."
D) "I feel better, and I am ready to go home."
Answer: B
Explanation: A) A client not skipping breakfast does not indicate the remission of any psychotic symptoms.
B) Among the therapeutic effects of risperidone (Risperdal) is the remission of a range of psychotic symptoms that include delusions, paranoia, auditory hallucinations, and irrational behavior.
C) A client going to group therapy does not indicate the remission of any psychotic symptoms.
D) A client ready to go home does not indicate the remission of any psychotic symptoms.
Page Ref: 1795
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 23.C. Analyze schizophrenia as it relates to cognition. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with schizophrenia.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with schizophrenia.

9) The nurse is caring for the client prescribed a first-generation antipsychotic. Which assessment findings alert the nurse to the possibility that the client has developed tardive dyskinesia? **Select all that apply.**

A) Wormlike motions of the tongue

B) Lip smacking

C) Unusual facial movements

D) Muscle spasms of the neck

E) Shuffling gait

Answer: A, B, C

Explanation: A) Tardive dyskinesia is characterized by unusual tongue movements such as wormlike motions.

B) Tardive dyskinesia is characterized by unusual mouth movements such as lip smacking.

C) Tardive dyskinesia is characterized by unusual face movements.

D) Severe muscle spasms of the neck is termed acute dystonia.

E) Parkinsonism causes a shuffling gait.

Page Ref: 1796

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 23.C. Analyze schizophrenia as it relates to cognition. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with schizophrenia.

MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with schizophrenia.

10) An adolescent client is admitted to the hospital for the treatment of schizophrenia. The client's mother is confused and wants to know what caused this to occur. Which responses by the nurse are appropriate? **Select all that apply.**

A) "Schizophrenia is a biological brain disorder."
B) "Research indicates that schizophrenia is a genetic disorder."
C) "Research indicates that a very stressful environment causes schizophrenia."
D) "Schizophrenia is due to too much dopamine in certain parts of the brain."
E) "Schizophrenia is linked to drinking alcohol during pregnancy."

Answer: A, B, D

Explanation: A) Theories explaining the cause of schizophrenia include a biologic brain disorder.
B) Theories explaining the cause of schizophrenia include a genetic component.
C) A stressful environment will exacerbate the symptoms of schizophrenia but does not cause the illness.
D) Theories explaining the cause of schizophrenia include overactive dopaminergic pathways in the basal nuclei.
E) There is no evidence to support a link between schizophrenia and alcohol consumption during pregnancy.

Page Ref: 1789
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 23.C. Analyze schizophrenia as it relates to cognition. Describe the pathophysiology of schizophrenia.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with schizophrenia.

11) Which statement regarding the pathophysiology and etiology of schizophrenia is correct?
A) "Brain imaging shows that there is reduced gray matter in the thalamus, frontal lobe, and temporal lobes."
B) "There is an increased number of nicotinic receptors in the hippocampus, which makes it harder to form new memories and interpret sensory stimuli."
C) "Genetics does not seem to factor into the cause of the disease."
D) "The ventricles and sulci of the brain are decreased in size."
Answer: A
Explanation: A) Brain imaging studies of individuals with schizophrenia consistently reveal a pattern of structural abnormalities that include decreased volumes of gray matter in the prefrontal cortex, temporal lobes, hippocampus, and thalamus; enlarged ventricles and sulci; and decreased blood flow to the frontal lobe, thalamus, and temporal lobes.
B) A decreased number of nicotinic receptors in the hippocampus makes it harder for the client with schizophrenia to form new memories and interpret sensory stimuli.
C) Genetics seems to factor into the cause of the disease, as familial patterns of the disease are noted.
D) In the client with schizophrenia, the ventricle and sulci of the brain are increased in size.
Page Ref: 1789
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Client/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Assessment
Learning Outcome: 23.C. Analyze schizophrenia as it relates to cognition. Describe the pathophysiology of schizophrenia.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with schizophrenia.

12) A client with schizophrenia is manifesting positive symptoms of the disease. Which finding will the nurse expect to assess in this client?
A) Social withdrawal
B) Hallucinations
C) Anhedonia
D) Concrete thinking
Answer: B
Explanation: A) Social withdrawal is a negative symptom.
B) Hallucinations are a positive symptom.
C) Anhedonia is a negative symptom.
D) Concrete thinking is a cognitive symptom.
Page Ref: 1790
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 23.C. Analyze schizophrenia as it relates to cognition. Apply the nursing process in providing culturally competent care to an individual with schizophrenia.
MNL LO: Demonstrate understanding of the concept of cognition in the care of a patient with schizophrenia.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 24 Culture and Diversity

The Concept of Culture and Diversity

1) A female client from a male-dominated culture is being discharged after a lengthy hospitalization. Which action by the nurse prior to providing discharge instructions is appropriate?
A) Assess who the decision maker is in the family.
B) Ensure that the healthcare provider gives the instructions.
C) Make sure instructions are understood by the client.
D) Ask the client when the best time for teaching would be.
Answer: A
Explanation: A) The nurse needs to identify who has the "authority" to make decisions in a client's family. If the decision maker is someone other than the client, the nurse needs to include that individual in healthcare discussions. Nurses need an awareness of cultural variations of gender because they will be caring for diverse client needs. What might be considered sexism by one culture may not be in another.
B) The nurse should not simply leave giving instructions to the healthcare provider.
C) Regardless of who is present during the teaching, it is always necessary to make sure that the instructions are understood, but it is difficult to do that before instructions are given.
D) Asking the client when the best time for teaching would be does not address the need for the decision maker of the family to be present.
Page Ref: 1813

Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Assessment
Learning Outcome: 24.3. Describe how cultural disparities and differences affect health care.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

2) The nurse is working in a busy emergency department of a hospital situated in a culturally diverse area of the city. Which should the nurse do when providing culturally competent care?
A) Acquire the underlying background knowledge necessary to provide these clients with the best possible healthcare.
B) Treat everyone who comes to the emergency department seeking care as having the same needs.
C) Assume that working in this emergency department will be the same as in other care contexts the nurse has encountered.
D) Base the standard of care on the needs and attitudes of the dominant cultural group in the area.
Answer: A
Explanation: A) As healthcare providers, it is imperative to recognize common prejudices. Prejudices are prejudgments about cultural groups or vulnerable populations that are unfavorable or false because they have been formed without the background knowledge and context upon which to form an accurate opinion. Healthcare providers must acquire this background knowledge to develop their cultural competence.
B) The nurse cannot treat every client as having the same needs.
C) The nurse cannot, assume that the emergency department does not present a unique context that must be understood on its own terms.
D) The nurse cannot base care on what best serves a single cultural group, dominant or not.
Page Ref: 1821
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.1 Engage with the individual in establishing a caring relationship. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Implementation
Learning Outcome: 24.5. Analyze the need for developing cultural competence.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

3) The nurse is explaining the need to obtain laboratory tests for a client who has an infection and is of a cultural group different from the nurse's. Which conclusion should the nurse make when the client avoids eye contact and refrains from answering questions for long periods of time?
A) In this client's culture, direct eye contact may show disrespect.
B) The nurse should come back at a different time when the client is feeling more communicative.
C) The nurse should have another nurse finish the interview who might be more culturally aware of this group's customs.
D) Leave the room and come back after having learned more about this particular culture.
Answer: A
Explanation: A) Nonverbal communication includes silence, touch, eye movement, facial expressions, and body posture. In some cultures, direct eye contact may indicate disrespect. In addition, some cultures are quite comfortable with long periods of silence. Before assigning meaning to nonverbal behavior, the nurse must consider the possibility that the behavior may have a different meaning for the client and family.
B) The nurse should not leave to come back later.
C) The nurse should not find another nurse to take over this client's care.
D) Nurses should be able to communicate with clients from a diversity of backgrounds.
Page Ref: 1817
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Assessment
Learning Outcome: 24.3. Describe how cultural disparities and differences affect health care.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

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4) A client from a different culture recovering from a myocardial infarction is receiving atorvastatin (Lipitor) and ingests a high-fat diet. Which action should the nurse take to improve the client's diet and reduce the risk for additional medications?
A) Ask the client if a nurse from the same culture is preferred to discuss dietary needs.
B) With the client's permission, discuss the dietary requirements with whoever prepares meals for the family.
C) Consult a dietitian to teach the client about low-fat diets.
D) Give the client information specific to the culture related to low-fat diets.
Answer: B
Explanation: A) Asking the client about having a nurse from the same culture talk about the diet is racist and implies that the nurse cannot understand the dietary needs of a client from another culture.
B) Every culture has culture-specific diets; the nurse must include the individual in the family who does the meal preparation if a different diet is to be successful.
C) A consult by dietary services is premature.
D) Providing information is a good idea, but the nurse must also teach the client.
Page Ref: 1824
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Planning

Learning Outcome: 24.6. Summarize the nursing process in the context of cultural competence.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

5) A client has not been able to achieve the goal of selecting low-fat foods from a list by the end of the month because of having different beliefs about food. Which action should the nurse take?
A) Extend the time frame and give the client a longer period to achieve the goal.
B) Select a different goal.
C) Make sure that the client understands the importance of the goal.
D) Modify the plan of care to be consistent with the client's beliefs regarding food.
Answer: D
Explanation: A) Extending the time frame may not be as helpful as looking at the cultural practices–including dietary ones–of the client.
B) Selecting a different goal may not be as helpful as looking at the cultural practices–including dietary ones–of the client.
C) Checking if the client understands the importance of the goal may not be as helpful as looking at the cultural practices–including dietary ones–of the client.
D) If the outcomes are not achieved for a client with different beliefs, the nurse should be especially careful to consider whether the client's belief system has been adequately included as an influencing factor and modify the plan of care to be consistent with the client's belief regarding food.
Page Ref: 1824
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Evaluation
Learning Outcome: 24.3. Describe how cultural disparities and differences affect health care.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

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6) A client from a different culture requests a caregiver to be of the same gender. Which response should the nurse make?
A) "You will be in bed so it does not matter if your caregiver is male or female."
B) "The male and female providers both respect privacy."
C) "The request is unreasonable and cannot be honored."
D) "Every attempt will be made to honor your request."
Answer: D
Explanation: A) The response that the client will be in bed is insensitive to the client's cultural needs.
B) Although both male and female staff have professional and ethical responsibilities to respect a client's privacy, the nurse must still make efforts to meet the request of the client.
C) Although both male and female staff have professional and ethical responsibilities to respect a client's privacy, the nurse must still make efforts to meet the request of the client.
D) Many cultures have religious beliefs that prohibit care being provided by a member of the opposite gender. To provide culturally appropriate care, the nurse must recognize this as a legitimate request and make every attempt to honor this request.
Page Ref: 1820
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Implementation

Learning Outcome: 24.3. Describe how cultural disparities and differences affect health care.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

7) A client with sepsis after a miscarriage refuses antibiotics because of having an affair outside of marriage. Which response should the nurse make?
A) "I'll notify your healthcare provider about your decision."
B) "Do you think you should be punished because you had a miscarriage?"
C) "I think you need to do what is best for you."
D) "You have a serious infection and really need the medication."
Answer: D
Explanation: A) Calling the healthcare provider is inappropriate; the nurse knows the client needs the medication.
B) Asking the client if she thinks she should be punished is inappropriate; she is septic and needs the medication.
C) Telling the client she needs to do what is best is inappropriate; the nurse knows she needs the medication.
D) Telling the client she needs the medication is providing the best care possible.
Page Ref: 1823-1824
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Implementation
Learning Outcome: 24.6. Summarize the nursing process in the context of cultural competence.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

8) A client from a culture that does not express pain is recovering from abdominal surgery. Which action should the nurse take when the client refuses pain medication when assessment data proves otherwise?
A) Seek out a family member to convince the client to take the medication.
B) Consult with the healthcare provider about providing pain medication without the client's knowledge.
C) Offer the pain medication to the client again, stating that providing comfort is the nurse's most important responsibility.
D) Allow the client to suffer in silence.
Answer: C
Explanation: A) Seeking out the intervention of a family member of the client is not an appropriate action.
B) Trying to administer the medication without the client's knowledge is not an appropriate action.
C) Members of some cultures will typically not complain of pain or physical problems because they are taught self-restraint and the priority of the group over individual needs. Many people from these cultures will consider refusal of something offered as a gesture of courtesy. The nurse should take this into account when offering the pain medication to the client in a culturally sensitive way.
D) Allowing the client to suffer in silence is not an appropriate action.
Page Ref: 1819
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Implementation

Learning Outcome: 24.6. Summarize the nursing process in the context of cultural competence.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

9) The mother of an infant with colic wants to use an herbal remedy to treat the condition. Which action should the nurse take?
A) Ask the mother what the ingredients are in the remedy.
B) Give the mother an alternate remedy for colic.
C) Explain how herbal ingredients may be harmful to the infant.
D) Tell the mother not to use the remedy because there is no way to know what the ingredients' scientific effect may be.
Answer: A
Explanation: A) To recognize cultural practices, the nurse must acknowledge that use of old and home remedies is part of caregiving practices. Asking the mother what ingredients are in the herbal remedy allows the nurse to best evaluate what the mother is using, and then determination of the benefit or detriment to the infant can be made in a nonjudgmental manner.
B) Giving an alternative does not recognize this cultural practice and shows insensitivity on the part of the nurse.
C) Explaining how herbal ingredients may be harmful to the infant does not recognize this cultural practice and shows insensitivity on the part of the nurse.
D) Telling the mother not to use the remedy does not recognize this cultural practice and shows insensitivity on the part of the nurse.
Page Ref: 1822
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Implementation

Learning Outcome: 24.6. Summarize the nursing process in the context of cultural competence.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

10) During a sexual history, the client states, "I have always felt like a man trapped in a woman's body." Which term will the nurse use to describe the client's statement?
A) Bisexual
B) Heterosexual
C) Homosexual
D) Transgender
Answer: D
Explanation: A) This client's statement relates to gender identification, not to the sexuality of the client.
B) This client's statement relates to gender identification, not to the sexuality of the client.
C) This client's statement relates to gender identification, not to the sexuality of the client.
D) The term transgender refers to individuals whose gender is not the same as the assigned sex.
Page Ref: 1813
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Assessment
Learning Outcome: 24.1. Describe the language used to describe cultural diversity.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

11) The nurse who cares for clients in an inner-city clinic overhears a coworker say that the clients are gang members and have guns. Which response by the nurse is appropriate?
A) "It's very difficult for me when you discriminate like that."
B) "It's okay because I'm not a gang member, so I will be okay."
C) "Hey, it's a job like any other job. All jobs have problems."
D) "That's an unfortunate stereotype. Can we talk about the reality?"
Answer: D
Explanation: A) Saying that the comment is discriminatory may increase conflict.
B) Saying that the nurse is not a gang member does not support cultural sensitivity.
C) Saying that the care provided is a "job" does not support cultural sensitivity.
D) It is the nurse's role to confront stereotyping to produce change.
Page Ref: 1813
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Implementation
Learning Outcome: 24.5. Analyze the need for developing cultural competence.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

12) A nurse is interviewing a client at a clinic near a shelter for the homeless. Understanding the lack of resources this client has available, which should the nurse assess during the intake phase of the health history? **Select all that apply.**

A) Social support available
B) Access to medication
C) Access to nutritious meals
D) Number of times married
E) Any personal resources

Answer: A, B, C, E

Explanation: A) Homeless clients present unique and complex challenges. The nurse should inquire about any social support.

B) Homeless clients present unique and complex challenges. The nurse should inquire about any access to prescribed medications.

C) Homeless clients present unique and complex challenges. The nurse should inquire about access to nutritious meals in order to plan care appropriately.

D) The number of times the client has been married is irrelevant.

E) Homeless clients present unique and complex challenges. The nurse should inquire about any personal resources in order to plan care appropriately.

Page Ref: 1814
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Assessment
Learning Outcome: 24.3. Describe how cultural disparities and differences affect health care.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

13) The nurse is caring for clients at a free clinic. Which client population is at the highest risk for low levels of healthcare?
A) Undocumented immigrants
B) Men who have protected sex with men
C) Men who have sex with women
D) Adolescents
Answer: A
Explanation: A) The term "vulnerable population" refers to groups of people in our culture who are at greater risk for diseases and reduced life span due to lack of resources and exposure to more risk factors. People may be made vulnerable by immigration status.
B) Men as a group are not more likely to be at risk for lower levels of healthcare.
C) Men as a group are not more likely to be at risk for lower levels of healthcare.
D) Adolescents as a group are not more likely to be at risk for lower levels of healthcare.
Page Ref: 1814
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 3.3 Consider the socioeconomic impact of the delivery of health care. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Assessment
Learning Outcome: 24.3. Describe how cultural disparities and differences affect health care.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

14) The nurse cares for clients in a homeless shelter. Which treatment program would be most appropriate for a homeless client whose type 1 diabetes requires daily insulin injections?
A) Home healthcare
B) Outpatient clinic
C) Partial hospitalization programs
D) Inpatient hospital-based care
Answer: B
Explanation: A) Because the client is homeless, home healthcare would not be the best option in this situation.
B) The outpatient clinic would provide the care the client requires in the most cost-effective manner.
C) There is no indication for partial hospitalization at this time.
D) There is no indication for inpatient hospitalization at this time.
Page Ref: 1770
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Planning
Learning Outcome: 24.3. Describe how cultural disparities and differences affect health care.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

15) The new nurse working in an inner-city hospital that serves a diverse client population states, "I want to learn everything possible about all of the clients." Which response by the nurse manager is appropriate?

A) "I will give you a great book that describes all of the critical factors."

B) "You should always be nonjudgmental."

C) "This will come with time as you get to know clients and then encounter problems."

D) "You need to first understand who you are."

Answer: D

Explanation: A) Reading about culture can be incorporated after engaging in a self-awareness inventory.

B) Remaining nonjudgmental is a strategy that can be incorporated after engaging in a self-awareness inventory.

C) Although experience working with diverse clients will help, it will be more meaningful after engaging in a self-awareness inventory.

D) It is a priority for the nurse to develop an awareness of personal perceptions, prejudices, and stereotypes regarding the client populations that are served.

Page Ref: 1821

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 9.1 Demonstrate an ethical comportment in one's practice reflective of nursing's mission to society. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Implementation

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Learning Outcome: 24.2. Analyze how values and beliefs are components of cultural diversity.

MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

16) The nurse is planning care for an older adult client. Which type of bias should be the nurse be careful to avoid when caring for this client?
A) Relativism
B) Fundamentalism
C) Ageism
D) Multiculturalism
Answer: C
Explanation: A) Relativism is an ethical philosophy.
B) Fundamentalism is an ethical philosophy.
C) Ageism is discrimination against older adults, which the nurse should guard against when caring for this client to ensure that no care reflects biases about older adults.
D) Multiculturalism is many cultures existing in a society in which no culture dominates.
Page Ref: 1815
Cognitive Level: Remembering
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Planning
Learning Outcome: 24.2. Analyze how values and beliefs are components of cultural diversity.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

17) The nurse working in an assisted living facility is preparing an educational program regarding ageism for the colleagues on the unit. Which statements reflect ageism? **Select all that apply.**
A) "If the client is competent to make decisions, I should not go to other members of the family for care decisions."
B) "The elderly are just lazy, and that is why they need help with activities of daily living."
C) "All elderly people are sickly."
D) "Addressing an elderly client as 'Honey' or 'Sweetie' is disrespectful."
E) "The elderly are less likely to recover from illness."
Answer: B, C, D, E
Explanation: A) The nurse should always involve the client in care decisions if the client is competent to decide.
B) Ageism is the term used to describe the deep and profound prejudice in American society against older adults. The beliefs that elderly people are lazy is an example of ageism.
C) Ageism is the term used to describe the deep and profound prejudice in American society against older adults. The beliefs that elderly people are sickly is an example of ageism.
D) The nurse should always address the client by name.
E) Ageism is the term used to describe the deep and profound prejudice in American society against older adults. The beliefs that elderly people are less likely to recover from illness is an example of ageism.
Page Ref: 1815
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Assessment
Learning Outcome: 24.2. Analyze how values and beliefs are components of cultural diversity.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

18) The nurse is caring for a client who emigrated from another country. Which behavior will the nurse observe that indicates the client has acculturated to the United States society?
A) The client buys all needed products from the local store owned by people from the client's country.
B) The client lives in a neighborhood that is populated predominantly with people from the client's country.
C) The client speaks his native language only.
D) The client attends church in the neighboring community to meet new people.
Answer: D
Explanation: A) Using stores of those from the client's country indicates that the client is comfortable only with those from the client's culture.
B) Living in a neighborhood with people from the client's culture does not indicate acculturation.
C) Speaking only the native language does not indicate acculturation.
D) Individuals experience acculturation when they begin to adapt or borrow habits of the new culture. The client who attends church in the neighboring community to meet new people is displaying acculturation.
Page Ref: 1812
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Assessment

Learning Outcome: 24.4. Outline the relationship between culture and diversity and other concepts.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

19) The nurse notices that a client, who is from another country, appears uncomfortable when asked to look at the abdominal incision from a recent surgery. Which nursing action is the most culturally competent?
A) Close the client's curtain to maintain privacy.
B) Ask the client to explain the discomfort.
C) Explain the reason for the intervention using lay terms.
D) Wait until the next assessment time to observe the incision.
Answer: C
Explanation: A) The nurse should close the client's curtain to maintain privacy for all clients; this is not necessarily just a culturally competent action.
B) Asking the client to explain the discomfort is confronting the client and is not culturally competent.
C) The most culturally competent intervention is to explain to the client the reason for the intervention using lay terms.
D) Waiting until the next assessment time to observe the incision is inappropriate, as this can lead to missing important assessment findings regarding the state of the client's incision.
Page Ref: 1819
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Implementation

Learning Outcome: 24.3. Describe how cultural disparities and differences affect health care.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

20) The nurse is caring for a client who comments that there are "gays" in the waiting room. Which term should the nurse use to describe the client's behavior?
A) Ageism
B) Transgender
C) Homophobia
D) Heterosexism
Answer: C
Explanation: A) Ageism is discrimination against older adults.
B) Transgender refers to individuals whose gender is not the same as their assigned sex.
C) Homophobia is a fear, hatred, or mistrust of gays and lesbians often expressed in overt displays of discrimination.
D) Heterosexism is a view of heterosexuality as the only correct sexual orientation.
Page Ref: 1815
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Assessment
Learning Outcome: 24.1. Describe the language used to describe cultural diversity.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

21) The nurse caring for an adult client from another country notices that the client consults with a parent on all healthcare decisions. What action by the nurse is the most culturally competent?
A) Ask the client why the parent is being consulted for every decision.
B) Accept the behavior of the client and family member.
C) Ask the client's mother to leave the room to provide the client with more privacy.
D) Tell the parent that the client can make the decisions.
Answer: B
Explanation: A) Asking why the parent is being consulted does not consider the client's cultural, family, or personal values.
B) In a multicultural society, human differences are accepted and respected. The nurse should accept this behavior because it might be a cultural norm, or it may be the way this client prefers to approach decisions about healthcare.
C) Asking the parent to leave the room does not consider the client's cultural, family, or personal values.
D) Telling the parent that the client can make the decisions does not consider the client's cultural, family, or personal values.
Page Ref: 1811
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; be open and nonjudgmental. | Nursing Process: Implementation

Learning Outcome: 24.6. Summarize the nursing process in the context of cultural competence.
MNL LO: Analyze the concept of culture and diversity and its application to nursing care.

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Module 25 Development

The Concept of Development

1) A 20-month-old child is unable to stand alone. Which aspect of development does the nurse identify as altered?
A) Behavior
B) Height
C) Motor
D) Growth
Answer: C
Explanation: A) Behavior is a component of each developmental stage and can sometimes indicate that development has taken place, but its absence does not mean that development has not occurred.
B) Height is one indicator of growth.
C) Development is an increase in the complexity of function and skill progression, the capacity of an individual to adapt to the environment. It includes changes in a person's cognitive, psychosocial, and gross and fine motor skills. In this case, the child's inability to stand is indicative of a delay in motor development.
D) Growth refers to physical change and increase in size; it does not entail changes in skills and abilities.
Page Ref: 1838
Cognitive Level: Analyzing

Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.1. Describe the course of normal development.
MNL LO: Analyze the concept of development and its application to nursing care.

2) The nurse is assessing a 6-month-old child. Which action should the nurse take if the client has gross motor delays?
A) Pull the child to a sitting position and prop the child in that position.
B) Encourage the child to hold a rattle or play patty-cake.
C) Talk to the child and play music.
D) Encourage the child to pull up to a standing position.
Answer: A
Explanation: A) The infant at 6 months should have head control and is working on sitting without support. Pulling the child to a sitting position allows the neck muscles to support the head. Propping the child in a sitting position helps to develop self-righting behaviors.
B) Handling a rattle is a fine motor behavior, not a gross motor behavior.
C) Talking to the child promotes language development, not gross motor development.
D) It is too early to worry about standing.
Page Ref: 1836
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.4. Differentiate alterations in development.
MNL LO: Analyze the concept of development and its application to nursing care.

3) The nurse is preparing a teaching tool for parents of preschool-age children. Which activities should the nurse emphasize to foster development in these children?
A) Providing time for playing sports, such as basketball, to increase gross motor skills
B) Helping them develop skills needed in the adult world, such as allowance budgeting
C) Allowing "pretend" time, such as dress-up or role-playing activities
D) Presenting diversity in culture and practices as part of home-based study
Answer: C
Explanation: A) Gross motor activities are also important, but children this age prefer activities such as swinging, riding a tricycle, and throwing a ball to organized sports.
B) School-age children are motivated by activities that provide a sense of worth. They concentrate on mastering skills that will help them function in the adult world.
C) Preschool-aged children should be given activities that focus on make-believe and pretend opportunities.
D) Understanding diversity, role preference, and performance is the task of the adolescent.
Page Ref: 1841
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Client/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 25.6. Explain the promotion of healthy development.
MNL LO: Analyze the concept of development and its application to nursing care.

4) A community nurse is planning an educational program about the developmental tasks of adults ages 50 to 60. According to Gould's theory, which task should the nurse emphasize?
A) Engaging in self-reflection
B) Viewing personality as set
C) Adjusting to decreasing physical capacities
D) Undergoing a period of transformation
Answer: D
Explanation: A) Self-reflection occurs in stage 5 of Gould's theory, during the ages 35-43.
B) Gould's theory states that personalities are set at ages 43-50.
C) Adjusting to decreasing physical capacities is a part of Peck's theory.
D) According to Gould, the seventh stage of adult development is experienced by individuals ages 50-60 and is a period of transformation.
Page Ref: 1831
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.2. Analyze theories of growth and development.
MNL LO: Analyze the concept of development and its application to nursing care.

5) The nurse is observing moral perspectives of male and female participants in a group therapy session. Which observation should the nurse identify that is most consistent with Gilligan's theory of moral development?
A) The men are focused on human-made rules governing morality.
B) The women have difficulty looking at moral issues objectively.
C) The men believe that morality is tied to relationships and caring.
D) The women perceive morality from a relationship and caring standpoint.
Answer: D
Explanation: A) According to Gilligan, men tend to consider what is right to be what is just.
B) Gilligan did not propose that women have difficulty looking at moral issues objectively.
C) Gilligan did not propose that men believe morality is tied to relationships and caring.
D) Gilligan proposed that women perceive mortality from a relationship and caring standpoint.
Page Ref: 1834
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.2. Analyze theories of growth and development.
MNL LO: Analyze the concept of development and its application to nursing care.

6) The parent of a preschool-age child asks when the child will begin to perform more self-care activities. Which recommendation should the nurse make that is supported by Bandura's social learning theory?
A) Punish the child if he does not complete the personal care tasks independently.
B) Refuse to help the child with the tasks and insist he do them on his own.
C) Model the tasks and positively reinforce the child for completing the tasks independently.
D) Wait until the child reaches the concrete operational phase before asking him to complete the tasks.
Answer: C
Explanation: A) Negative reinforcement like punishment is not part of Bandura's theory; it is more closely aligned with Skinner's behaviorist theory.
B) Refusing assistance to the child does not align with Bandura's belief in the need for modeling.
C) According to Bandura, children imitate the behavior they see; if the behavior is positively reinforced, they tend to repeat it.
D) The concrete operational phase is part of Piaget's theory and not Bandura's.
Page Ref: 1832
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.2. Analyze theories of growth and development.
MNL LO: Analyze the concept of development and its application to nursing care.

7) The nurse is assessing a child who was last seen in the clinic 2 years earlier. Which characteristic of the child should the nurse anticipate as having remained relatively stable over time?
A) Behavior
B) Physical characteristics
C) Temperament
D) Home environment
Answer: C
Explanation: A) A child's behaviors should be expected to change over time as a normal part of development.
B) Physical characteristics include eye color and height; although some physical characteristics remain constant as a child grows, others do not.
C) Temperament refers to innate characteristics that do not change over time. Each individual brings these characteristics to the events of daily life, and they set the stage for the interactive dynamics of growth and development.
D) A child's home environment may change at any time due to any number of factors.
Page Ref: 1833
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.5. Outline the relationship between development and other concepts.
MNL LO: Analyze the concept of development and its application to nursing care.

8) The nurse is performing developmental assessments on several children in a pediatric clinic setting. Which child should the nurse recognize is exhibiting a delay in meeting the expected developmental milestones? **Select all that apply.**
A) A 2-year-old who is unable to cut with scissors
B) A 2-year-old who cannot recite her phone number
C) A 3-year-old who is unable to speak in sentences
D) A 5-year-old who is unable to button a shirt
E) A 6-year-old who is unable to sit still for a short story
Answer: C, D, E
Explanation: A) A child who cannot cut with scissors by kindergarten age is considered developmentally delayed, but a 2-year-old is not expected to be able to do this.
B) A 2-year-old is not expected to be able to recite a phone number.
C) A 3-year-old is usually able to speak in sentences.
D) A 5-year-old should be able to button a shirt.
E) A 6-year-old should be able to sit still for a short story; this is a task that children between 3 and 5 years old are typically able to do.
Page Ref: 1838, 1840
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Client/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.3. Summarize the developmental milestones of individuals across the lifespan.
MNL LO: Analyze the concept of development and its application to nursing care.

9) The nurse is caring for an adolescent with a chronic illness who suddenly becomes noncompliant with the medication regimen. Which intervention should the nurse choose to help improve medication compliance for this client?
A) Give the client a computer-animated game that presents information on the management of the condition.
B) Recommend to the client's parents that certain privileges should be taken away, such as cell phone use and texting, if compliance fails to improve.
C) Arrange for the physician to discuss the risks related to noncompliance with medications to the client.
D) Set up a meeting with some older teens with the same condition who have been managing their disease effectively.
Answer: D
Explanation: A) Interest in games might begin to wane at this age.
B) Threatening punishment could further incite rebellion.
C) Adult opinions, even from a physician, could be viewed negatively and challenged.
D) Providing the adolescent with positive role models from their peer group is the intervention most likely to improve compliance.
Page Ref: 1845
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Client/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 25.6. Explain the promotion of healthy development.
MNL LO: Analyze the concept of development and its application to nursing care.

10) The nurse is teaching a school-aged client how to use a peak flow meter to monitor asthma. Which approach should the nurse take to support learning in this client?
A) Providing positive reinforcement after every attempt
B) Explaining that asthma can be fatal if not monitored and treated
C) Refusing to permit the child to play until learning to use the meter correctly
D) Using colloquialisms and slang when describing how to use the meter
Answer: A
Explanation: A) A sense of achievement is very important to school-aged children and rewarding and reinforcing behavior is most effective.
B) Scare tactics are not appropriate.
C) Negative reinforcement is not appropriate.
D) Nurses should use clear, concrete language to enhance understanding.
Page Ref: 1842
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Client/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 25.6. Explain the promotion of healthy development.
MNL LO: Analyze the concept of development and its application to nursing care.

11) The nurse notes that an infant does not seem to respond to noises in the environment and has difficulty following the movement of toys. Which diagnostic tools does the nurse anticipate will be used to further assess this client? **Select all that apply.**
A) CT scan of the brain
B) Vision test
C) Abdominal x-rays
D) Nerve conduction studies
E) Audiology testing
Answer: B, E
Explanation: A) There is not enough evidence to support that the child would need a CT scan of the brain.
B) The child is not responding to environmental noise and is having difficulty tracking the movement of toys. A vision test would be indicated.
C) There is not enough evidence to support that the child would need abdominal x-rays.
D) There is not enough evidence to support that the child would need nerve conduction studies.
E) The child is not responding to environmental noise and is having difficulty tracking the movement of toys. A hearing test would be indicated.
Page Ref: 1836
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 25.7. Differentiate common assessment procedures and tests used to examine development.
MNL LO: Analyze the concept of development and its application to nursing care.

12) The school nurse suspects that the needs for physical safety are not being adequately met for several students with physical challenges in the home environment. Which assessment findings support the nurse's concern? **Select all that apply.**

A) Wearing the same clothes to school several days of the week
B) Limited arm range of motion
C) Scrapes on knees caused by falling from a bicycle
D) Hand burn from touching a hot stove
E) Lunch contains leftovers from previous evening dinner

Answer: B, C, D

Explanation: A) Wearing the same clothes to school several days of the week could be an indication of the family's financial status.

B) Evidence that physical safety needs are not being adequately met would include the formation of contractures, which limits arm range of motion.

C) Scrapes on knees after falling from a bicycle, indicating the lack of safety or protective equipment for the head and extremities.

D) Hand burns obtained from touching a hot stove, could mean the child was not attended in the kitchen at home.

E) Eating leftovers for lunch could be an indication of the family's financial status.

Page Ref: 1854-1855

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 25.7. Analyze independent interventions nurses can implement for patients with alterations in development.

MNL LO: Analyze the concept of development and its application to nursing care.

13) A 6-month-old is in the clinic for a well-child visit. Which information from the Ages and Stages Questionnaire will the nurse use to complete an assessment?

A) Observation of the child's skills in a variety of areas

B) Parent reports of communication and motor skills, social skills, and problem-solving ability

C) Parental reports and observation of the child's skills in a variety of areas

D) Childcare provider reports of communication and motor skills, social skills, and problem-solving ability

Answer: B

Explanation: A) The Battelle Developmental Inventory Screening Test (BTDIST) uses both observation and parental reports to assess a variety of areas.

B) The ASQ relies on parental reports to assess the child's communication and motor skills, social skills, and problem-solving ability.

C) The Battelle Developmental Inventory Screening Test (BTDIST) uses both observation and parental reports to assess a variety of areas.

D) Tests specifically described in this chapter do not include those based solely on observation or childcare provider reports.

Page Ref: 1853

Cognitive Level: Remembering

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 25.7. Differentiate common assessment procedures and tests used to examine development.

MNL LO: Analyze the concept of development and its application to nursing care.

14) The nurse suspects that an older adult client may be minimizing pain level. Which reason should the nurse consider for the client to misreport the amount of pain?

A) Older adults see pain as a natural progression of aging, causing them to downplay the extent of their pain.

B) Older adults fear that admitting the extent of pain will result in administration of potentially addictive pain killers.

C) Older adults think that admitting the extent of their pain increases the likelihood they will be sent to a rehabilitation hospital prior to returning home.

D) Older adults have usually lost some degree of sensation in their appendages which makes it difficult for them to sense the full extent of their pain.

Answer: A

Explanation: A) Older adults see pain as a natural progression of aging. As such, many elderly patients tend to downplay the extent of their pain, which leads to undertreatment of pain.

B) Fear of addictive pain killers is unlikely to contribute to the older adult downplaying pain.

C) Fear of admission to a rehabilitation hospital is unlikely to contribute to the older adult downplaying pain.

D) Loss of sensation is unlikely to contribute to the older adult downplaying pain.

Page Ref: 1853

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 25.10. Differentiate considerations related to the assessment and care of patients with alterations in development throughout the lifespan.

MNL LO: Analyze the concept of development and its application to nursing care.

Exemplar 25.A Attention-Deficit/Hyperactivity Disorder

1) The school nurse is talking to a child with attention-deficit/hyperactivity disorder (ADHD) who wants to play soccer. Which action is *most* appropriate for the school nurse to take?
A) Recommend that the child become active in an individual sport, rather than a team sport.
B) Encourage the child to play soccer.
C) Discourage the child from playing a sport.
D) Ask the child's mother to get permission from the child's physician to play soccer.
Answer: B
Explanation: A) Some of the benefits of participating in a team sport would not be available with individual sports.
B) The child should be encouraged to play soccer. Participation in a team sport will assist the child with ADHD to expend some energy while cooperating with others and following game rules. Participating in a team sport can help promote self-esteem in the child with ADHD and encourage connectedness with other children.
C) There is no reason for a child with ADHD not to play sports.
D) The mother would not need physician approval for the child to play soccer. Vigorous physical activity is encouraged for all children with ADHD.
Page Ref: 1866
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.8 Promote self-care management. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 25.A. Analyze ADHD as it relates to development. Apply the nursing process in providing culturally competent care to an individual with ADHD.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with attention-deficit/hyperactivity disorder.

2) The nurse is interviewing the mother of a child who is being evaluated for attention-deficit/hyperactivity disorder (ADHD). When assessing the child's health history, which finding should the nurse identify as a risk factor for ADHD?
A) The measles, mumps, and rubella (MMR) vaccine
B) The immune response of the child
C) Young parental age at conception
D) Smoking during pregnancy
Answer: D
Explanation: A) The measles, mumps, and rubella vaccine was once thought to be associated with autism spectrum disorder, not ADHD, but multiple studies have found no link between immunizations and autism.
B) Immune response can be associated with autism spectrum disorders but not ADHD.
C) Young parental age has not been associated with ADHD.
D) Research shows that a mother's use of cigarettes during pregnancy can increase the risk for ADHD.
Page Ref: 1860
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.A. Analyze ADHD as it relates to development. Compare the risk factors and prevention of ADHD.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with attention-deficit/hyperactivity disorder.

3) A family has a child who has been diagnosed with attention-deficit/hyperactivity disorder (ADHD). Which statement made by a parent suggests that the family may have difficulty coping with this diagnosis?

A) "I don't know how to tell the rest of the family, and I'm not sure how we will manage the other children."

B) "We need to alert the teachers at school as soon as possible so they can work with us to develop a plan that meets my son's needs."

C) "What does this mean for my child's health in the future?"

D) "Given this diagnosis, I'm not sure if we should let our child act in the school play."

Answer: A

Explanation: A) The parent's comments about how to tell the family and manage the other children suggest that the family may have difficulty adjusting to the child's diagnosis. This family will likely need assistance with coping with the child and continuing on with life.

B) Alerting the teachers at school is a positive action and a way to protect the child.

C) Asking about the child's health in the future is reasonable at this time.

D) Decisions about participating in the school play should be discussed with the child's teachers, but the parent's statement does not suggest poor coping. Asking about the child's health in the future is reasonable at this time.

Page Ref: 1866

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 25.A. Analyze ADHD as it relates to development. Apply the nursing process in providing culturally competent care to an individual with ADHD.

MNL LO: Demonstrate understanding of the concept of development in the care of a patient with attention-deficit/hyperactivity disorder.

4) A school-age child with attention-deficit/hyperactivity disorder (ADHD) requires preoperative teaching for a surgical procedure. Which teaching technique should the nurse use?
A) Play a video describing the procedure to the child.
B) Ask other children who have had this procedure to talk to the child.
C) Allow the child to lead the teaching session to gain a sense of control.
D) Give instructions verbally and use a picture pamphlet, repeating points more than once.
Answer: D
Explanation: A) A video is not appropriate for this client because it may foster distraction, and it does not permit the client to ask questions until the program has concluded. Given this client's history of ADHD, it is unlikely that he or she will remember all such questions until the end of the video.
B) Talking to other children who have had this procedure may not foster understanding, because this child has ADHD.
C) The nurse, not the client, should lead the teaching session to make sure it progresses appropriately and covers all necessary information.
D) A teaching session for a child with ADHD should foster attention. Giving instructions verbally and in written form, repeating the main points, will improve learning for a child with ADHD.
Page Ref: 1867
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.A. Analyze ADHD as it relates to development. Apply the nursing process in providing culturally competent care to an individual with ADHD.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with attention-deficit/hyperactivity disorder.

5) The nurse is caring for a young school-age child who was recently diagnosed with attention-deficit/hyperactivity disorder (ADHD). Which statement by the child's mother requires follow up teaching?
A) "I will let my child do homework while watching a favorite television show."
B) "I will give my child ADHD medication with meals."
C) "I will take my child to the doctor every 3 months for a weight and height check."
D) "I will stick to the same routine each day after school."
Answer: A
Explanation: A) This child should do homework in a quiet environment, away from distractions.
B) Giving ADHD medication with meals will help counteract the anorexia associated with this medication.
C) Children with ADHD should be screened regularly for height and weight to monitor growth.
D) Maintaining the same daily routine helps the child know expectations, and a nighttime routine helps counteract insomnia.
Page Ref: 1867
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | Nursing Process: Evaluation
Learning Outcome: 25.A. Analyze ADHD as it relates to development. Apply the nursing process in providing culturally competent care to an individual with ADHD.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with attention-deficit/hyperactivity disorder.

6) The nurse is teaching the family of a child who is prescribed amphetamine mixed salts sustained release (Adderall XR) for attention-deficit/hyperactivity disorder (ADHD). Which information should the nurse teach the family about the *best* time to administer the medication?

A) Just before lunch
B) At bedtime
C) With the evening meal
D) Early in the morning

Answer: D

Explanation: A) Before lunch might be difficult and cause embarrassment to the child if the child is in school.
B) Bedtime is incorrect as this medicine can cause insomnia.
C) Evening is incorrect as this medicine can cause insomnia.
D) Administering the medication early in the day can help alleviate the effect of insomnia.

Page Ref: 1863
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.A. Analyze ADHD as it relates to development. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with ADHD.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with attention-deficit/hyperactivity disorder.

7) A community health nurse is teaching a group of women about the dangers of smoking. Which child health problem should the nurse mention is associated with smoking during pregnancy?
A) Benzodiazepine withdrawal
B) Attention-deficit/hyperactivity disorder (ADHD)
C) Vision impairment
D) Personality disorders
Answer: B
Explanation: A) Smoking during pregnancy is not related to benzodiazepine withdrawal.
B) Maternal smoking during pregnancy is associated with an increased risk for ADHD in children.
C) Smoking during pregnancy is not related to vision impairment.
D) Smoking during pregnancy is not related to personality disorders.
Page Ref: 1860
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.A. Analyze ADHD as it relates to development. Compare the risk factors and prevention of ADHD.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with attention-deficit/hyperactivity disorder.

8) A child with attention-deficit/hyperactivity disorder (ADHD) is prescribed amphetamine-dextroamphetamine (Adderall). Which information should the nurse include when teaching about this medication?
A) "Your child's liver function should be monitored with this medication."
B) "Your child's growth will need to be monitored on this medication."
C) "This medication may increase the risk of psychosis."
D) "This medication has less abuse tendency because it is not a stimulant."
Answer: B
Explanation: A) Liver function should be monitored with nonstimulant medications, not stimulants.
B) Amphetamine-dextroamphetamine (Adderall), a psychostimulant, may delay the child's growth, and height should be monitored frequently.
C) Nonstimulants, not stimulants, may increase the risk of psychosis.
D) Stimulant medications have a higher–not a lower–tendency to be abused.
Page Ref: 1863
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.A. Analyze ADHD as it relates to development. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with ADHD.

MNL LO: Demonstrate understanding of the concept of development in the care of a patient with attention-deficit/hyperactivity disorder.

9) A community health nurse is educating pregnant clients about the risk factors associated with the development of attention-deficit/hyperactivity disorder (ADHD). Which statement will the nurse include in the educational session?
A) "ADHD has not been linked to prenatal exposure or disease."
B) "ADHD has been linked to a specific gene, and genetic testing may help to diagnose this."
C) "ADHD has been linked to prenatal exposure to cigarette smoke."
D) "ADHD has been linked to childhood exposure to folate."
Answer: C
Explanation: A) ADHD has been linked to prenatal exposure or disease.
B) ADHD has not been linked to a specific gene.
C) Prenatal exposure to cigarette smoke increases the risk for the child to develop ADHD.
D) ADHD has been linked to childhood exposure to lead, not folate.
Page Ref: 1860
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.A. Analyze ADHD as it relates to development. Compare the risk factors and prevention of ADHD.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with attention-deficit/hyperactivity disorder.

10) The nurse is assessing a group of infants in the nursery who all had the same birth weight, level of prenatal care, and level of genetic predisposition. Which infant is least likely to develop ADHD during childhood?
A) An infant born at 35 weeks' gestation
B) An infant born at 36 weeks' gestation
C) An infant born at 38 weeks' gestation
D) An infant born at 34 weeks' gestation
Answer: C
Explanation: A) Preterm birth is a risk factor for ADHD. The infant born at 35 weeks is considered preterm.
B) Preterm birth is a risk factor for ADHD. The infant born at 36 weeks is considered preterm.
C) Preterm birth is a risk factor for ADHD. The infant born at 38 weeks is considered a term infant.
D) Preterm birth is a risk factor for ADHD. The infant born at 34 weeks is considered preterm.
Page Ref: 1860
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.A. Analyze ADHD as it relates to development. Compare the risk factors and prevention of ADHD.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with attention-deficit/hyperactivity disorder.

11) The nurse is preparing a teaching tool about attention-deficit/hyperactivity disorder (ADHD). Which clinical manifestation should the nurse identify that is more commonly observed in school-aged girls than in school-aged boys?
A) Aggression
B) Anxiety
C) Sleep disturbances
D) Impulsiveness
Answer: B
Explanation: A) Typically, girls with ADHD show far less aggression.
B) Typically, girls with ADHD show far more anxiety, mood swings, social withdrawal, rejection, and cognitive and language problems than boys.
C) Sleep disturbances are common in ADHD clients of both genders.
D) Impulsiveness is seen more frequently in boys with ADHD.
Page Ref: 1860
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.A. Analyze ADHD as it relates to development. Identify the clinical manifestations of ADHD.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with attention-deficit/hyperactivity disorder.

12) The nurse is completing a psychosocial assessment of an adult client. Which finding should the nurse identify that is most consistent with an adult with ADHD?
A) "The client stated that he has many friends and an active social life, and he thrives in fast-paced environments."
B) "The client stated that at times he feels tired and listless, struggling to get out of bed and complete basic self-care tasks."
C) "The client stated that he feels confident when completing job tasks and is punctual and effective at work, even though he has difficulty getting along with coworkers."
D) "The client stated that he struggles with alcohol use and often engages in unprotected sex and recreational drug use."
Answer: D
Explanation: A) Personal and social relationships tend to be difficult for adults with ADHD, so it is unlikely he would enjoy socializing with others.
B) Tiredness, listlessness, and inability to complete care tasks would be indicative of depression, not ADHD.
C) Adults with ADHD tend to struggle in the workplace.
D) Chemical dependence and participation in risky behaviors are common in adults with ADHD.
Page Ref: 1864
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 25.A. Analyze ADHD as it relates to development. Differentiate care of patients with ADHD across the lifespan.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with attention-deficit/hyperactivity disorder.

Exemplar 25.B Autism Spectrum Disorder

1) The nurse is assessing a toddler who is suspected of having autism spectrum disorder (ASD). Which question would be least useful to ask the parent when assessing the toddler for this condition?
A) "Does your child have manic or depressed episodes?"
B) "Tell me about your child's social interactions."
C) "Does your child perform ritualistic behaviors when performing activities?"
D) "Is your child able to name objects?"
Answer: A
Explanation: A) Manic or depressed episodes are characteristics of bipolar disorder, not autism.
B) Autism is characterized by social isolation.
C) Autism is characterized by strange repetitive behaviors.
D) Autism is characterized by impaired communication.
Page Ref: 1869
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.B. Analyze ASD as it relates to development. Identify the clinical manifestations of ASD.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with autism spectrum disorder.

2) The nurse reviews data collected during the assessment of a pregnant client. Which risk factors should the nurse identify that increases the risk for the baby to develop autism? **Select all that apply.**

A) Employed as a computer programmer
B) Smokes one pack per day of cigarettes
C) Drinks two glasses of wine on the weekends
D) Age 40
E) Rides a stationary bicycle four times a week for 30 minutes

Answer: B, C, D

Explanation: A) Employment status is not a risk factor for the development of autism.
B) Maternal smoking increases rates of autism.
C) Maternal use of alcohol during pregnancy increases rates of autism.
D) A maternal age of 40 or older increases the risk that a child will be born with autism.
E) Exercise level is not a risk factor for the development of autism.

Page Ref: 1870

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 25.B. Analyze ASD as it relates to development. Compare the risk factors and prevention of ASD.

MNL LO: Demonstrate understanding of the concept of development in the care of a patient with autism spectrum disorder.

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3) The nurse is teaching the caregiver of a child with autism spectrum disorder (ASD). Which behavioral problem should be identified in this teaching?
A) Depression in relation to feelings of inadequacy
B) Episodes of self-injury
C) Strong tendency toward hypoactivity
D) Hostility when faced with structured environments or repetitive activities
Answer: B
Explanation: A) These children typically have a restricted, repetitive repertoire of interests or behaviors, and therefore usually will not become depressed due to perceiving themselves as inadequate (although some children with high-functioning ASD may experience feelings of inadequacy).
B) Many children with a spectrum disorder have associated behavioral problems such as hyperactivity, aggressiveness, temper tantrums, and self-injurious behaviors like head banging.
C) These children also tend toward hyperactivity rather than hypoactivity, although this is not always the case.
D) Many children with ASD will have difficulty adapting to change, so they will prefer structured environments and consistent schedules.
Page Ref: 1861
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 25.B. Analyze ASD as it relates to development. Apply the nursing process in providing culturally competent care to an individual with ASD.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with autism spectrum disorder.

4) The parents of a child with autism spectrum disorder (ASD) observe that the child has difficulty making friends and are concerned about social expectations for their child. Which problem should the nurse make a priority for this client?
A) Risk of injury
B) Undernutrition
C) Sleep disturbance
D) Inadequate social skills
Answer: D
Explanation: A) Difficulty making friends will not increase the risk for injury.
B) Difficulty making friends will not increase the risk for undernutrition.
C) Difficulty making friends will not increase the risk for sleep disturbances.
D) Inadequate social skills will contribute to the difficulty in making friends.
Page Ref: 1865
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs.| | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 25.B. Analyze ASD as it relates to development. Apply the nursing process in providing culturally competent care to an individual with ASD.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with autism spectrum disorder.

5) The parent of a child with autism spectrum disorder (ASD) asks why family therapy has been prescribed. Which response by the nurse is most appropriate?
A) "Family therapy will help you learn how to assess your child's potential."
B) "Family therapy will provide your child with an opportunity to learn problem-solving skills."
C) "Family therapy will help you interact with your child."
D) "Family therapy will help you learn how to cope with your child's diagnosis."
Answer: D
Explanation: A) Family therapy is not used to learn how to assess the child's potential.
B) Family therapy is not used to help the child learn how to problem-solve.
C) Family therapy is not used to help with interpersonal interactions.
D) Parents of children with autism report more family problems, more marital problems, more depression, and more social isolation than parents of typically developing children or parents of children who are severely and persistently mentally ill. Family therapy will help them cope with the diagnosis through the problem-solving process.
Page Ref: 1862
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.B. Analyze ASD as it relates to development. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with ASD.
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MNL LO: Demonstrate understanding of the concept of development in the care of a patient with autism spectrum disorder.

6) The nurse is caring for a child newly diagnosed with autism spectrum disorder (ASD). Which outcome of care should the nurse identify for this client?

A) Function more effectively in social and emotional interactions

B) Stay on task

C) Acknowledge the effects of personal behavior on others

D) Acknowledge personal strengths

Answer: A

Explanation: A) Autism spectrum disorders involve difficulties in the quality of both the social interaction and the communication of the child.

B) Children with spectrum disorders may or may not be able to stay on task.

C) Children with spectrum disorders may or may not be able to acknowledge the effects of their behavior on others.

D) Children with spectrum disorders may or may not be able to acknowledge personal strengths.

Page Ref: 1865

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 25.B. Analyze ASD as it relates to development. Apply the nursing process in providing culturally competent care to an individual with ASD.

MNL LO: Demonstrate understanding of the concept of development in the care of a patient with autism spectrum disorders.

7) The nurse is providing education to the parents of a child diagnosed with ASD. Which healthcare professionals should the nurse tell the parents will take part in their child's care? **Select all that apply.**
A) Social services
B) Laboratory
C) Speech therapy
D) Play therapy
E) Public health agency
Answer: A, C, D
Explanation: A) The goals of therapy are to facilitate communication, reduce rigidity, and treat maladaptive behaviors. To reach these goals, the child will be treated by social services.
B) Laboratory technicians do not treat clients.
C) The goals of therapy are to facilitate communication, reduce rigidity, and treat maladaptive behaviors. To reach these goals, the child will be treated by a speech therapist.
D) The goals of therapy are to facilitate communication, reduce rigidity, and treat maladaptive behaviors. To reach these goals, the child will be treated by a play therapist.
E) A public health agency does not treat clients, although individuals who work there might.
Page Ref: 1861
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 25.B. Analyze ASD as it relates to development. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with ASD.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with autism spectrum disorder.

8) The nurse is caring for a child diagnosed with autism spectrum disorder (ASD) who is being admitted to the hospital with dehydration. Which action should the nurse take when the child arrives to the care area?

A) Take the child on a tour of the pediatric unit.
B) Take the child to the playroom for arts and crafts.
C) Quietly orient the child to a single-bed hospital room.
D) Orient the child to a four-bed unit.

Answer: C

Explanation: A) Taking a child with autism on a tour of the pediatric unit would be too much stimulation for this child.

B) Arts and crafts might be appropriate for an autistic child if done in the child's room but going to the playroom would be too much stimulation for this child.

C) Orienting a child with autism to a new environment is important, although this must be done in a quiet, controlled environment. A single room is the best place for an autistic child if the child must be hospitalized.

D) An autistic child should be in a single room, if possible, away from distractions.

Page Ref: 1876

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 25.B. Analyze ASD as it relates to development. Apply the nursing process in providing culturally competent care to an individual with ASD.

MNL LO: Demonstrate understanding of the concept of development in the care of a patient with autism spectrum disorder.

9) An adult client with ASD struggles with finding and maintaining employment. Which action by the nurse best addresses the client's needs?
A) Give the client information about state subsidies that will help him get by without a job.
B) Suggest the client work for a business owned by a family member or family friend.
C) Ask the client what his strengths are and identify types of jobs based on those strengths.
D) Encourage the client to seek opportunities that do not require communication with others.
Answer: C
Explanation: A) Many adults with ASD are financially subsidized by the state, but if the client wishes to work, the nurse should encourage him and help him with that goal.
B) Working for a family member or friend's business might help the client find a job but does not address the issues that make it difficult to keep a job.
C) Adults with ASD are most successful when they seek employment opportunities that play to their strengths.
D) Communication is a struggle with clients with ASD, but discouraging communication with others would not be appropriate, nor is it realistic in the workplace.
Page Ref: 1873
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.B. Analyze ASD as it relates to development. Differentiate care of patients with ASD across the lifespan.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with autism spectrum disorder.

10) A parent of a high school student with high-functioning ASD asks whether the child will ever be able to work. Which response by the nurse is best?
A) "There are job training programs that assist adults with ASD."
B) "Most adults with high-functioning ASD need to be supported by the state."
C) "You should plan to provide care for your child for the rest of your life."
D) "Individuals with high-functioning ASD usually grow out of the disorder."
Answer: A
Explanation: A) Many communities provide job training and supervised work programs for adults with ASD.
B) Many adults with ASD who cannot function independently or whose family can no longer provide care for them receive government subsidies, but there is no indication that this is the case for this client.
C) Although some adult patients with ASD do reside in group living environments, many live independently or with their parents.
D) It is incorrect to state that people can "grow out of" ASD.
Page Ref: 1873
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.B. Analyze ASD as it relates to development. Differentiate care of patients with ASD across the lifespan.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with autism spectrum disorder.

11) An individual with ASD demonstrates marked distress on switching activities. Which action should the nurse take?
A) Provide visual cues
B) Use focused interactions
C) Prepare a visual schedule
D) Remind to attend behavior therapy
Answer: D
Explanation: A) Visual cues would be appropriate for mild problems with organization.
B) Focused interactions would be appropriate for mild communication deficits.
C) A visual schedule would be appropriate for mild communication deficits.
D) Behavioral therapy would be appropriate for moderate-to-severe repetitive/restrictive behaviors.
Page Ref: 1871
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.B. Analyze ASD as it relates to development. Identify the clinical manifestations of ASD.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with autism spectrum disorders.

12) A child is using *you* in place of *I,* parroting words and phrases, and repeating questions rather than answering them. Which condition should the nurse suspect the client is experiencing?

A) Cerebral palsy
B) Autism spectrum disorder
C) Attention-deficit/hyperactivity disorder (ADHD)
D) Failure to thrive

Answer: B

Explanation: A) Speech abnormalities are generally not seen in cerebral palsy.

B) Using *you* in place of *I*, engaging in echolalia (compulsive parroting of a word of phrase just spoken by another), and repeating questions rather than answering them are speech patterns typically indicative of autism spectrum disorder.

C) Speech abnormalities are generally not seen in ADHD.

D) Speech abnormalities are generally not seen in failure to thrive.

Page Ref: 1870

Cognitive Level: Understanding

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 25.B. Analyze ASD as it relates to development. Identify the clinical manifestations of ASD.

MNL LO: Demonstrate understanding of the concept of development in the care of a patient with autism spectrum disorder.

Exemplar 25.C Cerebral Palsy

1) A 9-month-old client is diagnosed with ataxic cerebral palsy (CP). Which clinical manifestations does the nurse anticipate when assessing this client? **Select all that apply.**
A) Muscle instability
B) Hypotonia
C) Hemiplegia
D) Hypertonia
E) Tremors
Answer: A, B
Explanation: A) Muscle instability is seen in ataxic CP.
B) Hypotonia is seen in ataxic CP.
C) Hemiplegia is seen in spastic CP.
D) Hypertonia is seen in spastic CP.
E) Tremors are seen in dyskinetic CP.
Page Ref: 1880
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.C. Analyze CP as it relates to development. Identify the clinical manifestations of CP.

MNL LO: Demonstrate understanding of the concept of development in the care of a patient with cerebral palsy.

2) The nurse is providing teaching to a client who is concerned about giving birth to a child with cerebral palsy. Which risk factors would the nurse include? **Select all that apply.**

A) Cesarean delivery
B) Severe jaundice following birth
C) Infection and fever during pregnancy
D) Preterm labor
E) Birth weight of 9 pounds or above

Answer: B, C, D

Explanation: A) Breech delivery–not cesarean delivery–is a risk factor.
B) Severe jaundice in the neonatal period is also a risk factor.
C) Infections such as pelvic inflammatory disease (PID), rubella, and chickenpox in the pregnant mother and fever are all risk factors for CP.
D) The greatest risk factor, however, is preterm labor.
E) Low birth weight and not a high birth weight is a risk factor for CP.

Page Ref: 1878-1879
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.C. Analyze CP as it relates to development. Compare the risk factors and prevention of CP.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with cerebral palsy.

3) The nurse is planning care for a child with cerebral palsy (CP). Which problems should the nurse identify for this client? **Select all that apply.**

A) Compromised physical mobility
B) Risk of injury
C) Anxiety
D) Caregiver burden
E) Potential for undernutrition
Answer: A, B, D, E
Explanation: A) The child with CP will have issues with physical mobility.
B) The child with CP is at risk for injury because of an alteration in physical status.
C) Anxiety is not identified as a problem for a client with CP.
D) The caregiver of a child with CP is at risk for caregiver burden.
E) The child with CP is at risk for undernutrition.
Page Ref: 1883
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 25.C. Analyze CP as it relates to development. Apply the nursing process in providing culturally competent care to an individual with CP.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with cerebral palsy.

4) A child with cerebral palsy (CP) is being mechanically ventilated and cared for in the home. Which intervention best supports the needs of the family?
A) Meals-on-Wheels
B) Food stamps
C) Psychologic counseling
D) Respite care
Answer: D
Explanation: A) Meals-on-Wheels is a service intended for those who are shut-ins.
B) There is no evidence that the family is financially challenged and needs food stamps.
C) Counseling is an option, if and when the family shows signs of ineffective coping, which respite care is designed to help prevent.
D) The family members will need breaks from caring for the child in order to provide time for themselves and the other children.
Page Ref: 1884
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 25.C. Analyze CP as it relates to development. Apply the nursing process in providing culturally competent care to an individual with CP.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with cerebral palsy.

5) The nurse caring for a child with cerebral palsy (CP) is discussing the plan of care with the parents. Which goal should the nurse identify for this child?

A) Promoting optimal global development

B) Increasing the child's IQ level

C) Reversing the degenerative processes that have occurred

D) Curing the underlying defect

Answer: A

Explanation: A) Promoting optimal development in all areas is the goal of therapy with children with CP.

B) Most children with CP have normal IQs, but they might have behavior or perceptual problems.

C) CP is caused by an irreversible brain insult.

D) CP is caused by a probable brain insult and cannot be cured.

Page Ref: 1882

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 25.C. Analyze CP as it relates to development. Apply the nursing process in providing culturally competent care to an individual with CP.

MNL LO: Demonstrate understanding of the concept of development in the care of a patient with cerebral palsy.

6) A child with cerebral palsy (CP) is scheduled for casting of the lower extremities. Which information will the nurse include when teaching the client and family about the cast? **Select all that apply.**
A) Promote skeletal alignment
B) Maintain stability
C) Improve muscle tone
D) Improve muscle function
E) Control involuntary movements
Answer: A, B, E
Explanation: A) Serial casting is used to promote skeletal alignment.
B) Serial casting is used to maintain stability.
C) Serial casting will not improve muscle tone.
D) Serial casting will not improve muscle function.
E) Serial casting is used to control involuntary movements.
Page Ref: 1882
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 25.C. Analyze CP as it relates to development. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with CP.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with cerebral palsy.

7) A parent brings an 8-month-old baby for a routine examination. Which statement indicates to the nurse that the client might have cerebral palsy (CP)?
A) "My 6-month-old baby is rolling from back to prone now."
B) "My 8-month-old cannot sit without support."
C) "My 10-month-old is not walking."
D) "My 3-month-old smiles at me all the time."
Answer: B
Explanation: A) A baby rolls over from back to prone at 6 months.
B) Children with cerebral palsy are delayed in meeting developmental milestones. The infant who fails to sit unassisted at 8 months of age is showing a delay.
C) A baby walks at 12 months.
D) A baby smiles socially at 6 weeks.
Page Ref: 1880
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.C. Analyze CP as it relates to development. Identify the clinical manifestations of CP.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with cerebral palsy.

8) The nurse is preparing teaching for adult clients with cerebral palsy (CP). Which statement should the nurse include in the instructions?
A) "Adults with CP are at increased risk of bladder infections, which may result in incontinence."
B) "It's important to undergo regular depression screenings, because undiagnosed depression can contribute to incontinence."
C) "Clients with CP are prone to incontinence as they age."
D) "If you experience urinary incontinence, you will likely need to be assessed by a neurologist to see if the problem is related to nerve function."
Answer: C
Explanation: A) CP does not increase the risk of bladder infection.
B) Incontinence is often a cause of depression in CP patients, not the other way around.
C) As individuals with CP age, they are more prone to both urinary and bowel incontinence.
D) Urinary incontinence in adults with CP is usually not due to neurologic problems. In addition, the doctor–not the nurse–would refer the client to a neurologist.
Page Ref: 1883
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 25.C. Analyze CP as it relates to development. Differentiate care of patients with CP across the lifespan.

MNL LO: Demonstrate understanding of the concept of development in the care of a patient with cerebral palsy.

9) The nurse sees several adult clients between the ages of 30 and 40 for annual checkups, one of whom has CP. Which statement indicates to the nurse a common consequence of the stress state caused by CP?
A) "My muscles seem to always hurt all over, and my joints are sore a lot, too."
B) "I have a really hard time socializing and understanding nonverbal communication.
C) "There are times when I just cannot control my anger and I hurt other people."
D) "I just have no appetite lately, and I seem to get dehydrated a lot."
Answer: A
Explanation: A) The majority of adults with CP will have signs of premature aging by their early 40s. These include chronic pain due to the contractions of the muscles, arthritis due to the wear and tear on the joints, and persistent fatigue due to the extended energy needed to work against contracted muscles.
B) Difficulty socializing and understanding nonverbal cues are characteristic of adult ASD.
C) Aggression problems are characteristic of ADHD.
D) Lack of appetite and dehydration are typical of geriatric failure to thrive.
Page Ref: 1882
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.C. Analyze CP as it relates to development. Differentiate care of patients with ASD across the lifespan.

MNL LO: Demonstrate understanding of the concept of development in the care of a patient with cerebral palsy.

10) An infant is diagnosed with congenital CP caused by a meningitis infection. Which statement explains the pathophysiology for cellular damage causing this condition?
A) Genetic mutation to the brain cells prompted by infection with the causative agent
B) Accumulation of causative agents in the blood stream that gradually build up in the brain
C) Stretching and shearing of the neural pathways and brain tissue
D) Consumption of brain tissue and production of lactic acid by the causative pathogen
Answer: D
Explanation: A) Genetic mutations are not caused by infections.
B) Neurotoxins like bilirubin accumulate in the bloodstream and eventually damage nerve cells in the brain.
C) Trauma stretches and shears neural pathways and brain tissue.
D) *Streptococcus pneumonia* is the pathogen that causes meningitis in infants, and it causes cellular damage through consumption of the brain's tissue and production of the byproduct lactic acid.
Page Ref: 1878
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.C. Analyze CP as it relates to development. Describe the etiology of CP.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with cerebral palsy.

11) The nurse is assessing a baby. Which set of symptoms would the nurse identify as hypotonia?
A) Tense muscles and uncoordinated, awkward, stiff movements
B) Increased range of motion of joints, diminished reflex response, floppiness
C) Constant involuntary writhing motions that are more severe distally
D) Paralysis of one side of the body, with greater upper extremity dysfunction
Answer: B
Explanation: A) Tense or tight muscles and uncoordinated, awkward, stiff movements are typical of hypertonia.
B) Floppiness, increased range of motion of joints, and diminished reflex response are all hallmarks of hypotonia.
C) Constant involuntary writhing motions that are more severe distally are signs of athetosis.
D) Paralysis of one side of the body, with the upper extremities being more dysfunctional than the lower extremities, is indicative of hemiplegia.
Page Ref: 1879
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.C. Analyze CP as it relates to development. Describe the etiology of CP.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with cerebral palsy.

Exemplar 25.D Failure to Thrive

1) While conducting a well-child assessment, the nurse suspects that a 2-month-old has failure to thrive (FTT). Which height and weight measurement parameters should the nurse use to help diagnose this health problem?
A) Height and weight below the 50th percentile
B) Height and weight below the 15th percentile
C) Height and weight below the 5th percentile
D) Height and weight below the 10th percentile
Answer: C
Explanation: A) The parameter of 50th percentile is higher than that used to diagnose FTT.
B) The parameter of 15th percentile is higher than that used to diagnose FTT.
C) A child whose weight and height fall below the 5th percentile is diagnosed with failure to thrive.
D) The parameter of 10th percentile is higher than that used to diagnose FTT.
Page Ref: 1886
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.D. Analyze failure to thrive as it relates to development. Identify the clinical manifestations of failure to thrive.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with failure to thrive.

2) During a home visit, the nurse suspects that a newborn is at risk for failure to thrive (FTT). Which statement by the child's mother supports this assessment?

A) "I do not like to cook."

B) "I needed help at first learning to breastfeed my baby."

C) "I have a glass of wine with dinner once a week."

D) "I have been feeling depressed for the past several weeks."

Answer: D

Explanation: A) The mother's aversion to cooking will not affect the infant.

B) Needing help with breastfeeding is normal for a first-time mother.

C) A glass of wine once a week is appropriate.

D) The mother who is depressed and anxious may not be interacting appropriately with her infant and puts the child at risk for failure to thrive.

Page Ref: 1887

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 25.D. Analyze failure to thrive as it relates to development. Compare the risk factors and prevention of failure to thrive.

MNL LO: Demonstrate understanding of the concept of development in the care of a patient with failure to thrive.

3) A family is expressing difficulty managing the care of a child with intellectual deficits and failure to thrive (FTT). Which problem should the nurse identify as a priority for this family?
A) Fatigue
B) Undernutrition
C) Inadequate parenting
D) Potential for developmental delay
Answer: C
Explanation: A) Fatigue is not a priority problem for this situation.
B) The child is experiencing undernutrition, but this does not explain the issue with the family.
C) The problem of inadequate parenting would support the family's situation caring for the child.
D) The child is at risk for developmental delays; however, this does not explain the issue with the family.
Page Ref: 1889
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 25.D. Analyze failure to thrive as it relates to development. Apply the nursing process in providing culturally competent care to an individual with failure to thrive.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with failure to thrive.

4) The parents of an infant report that the baby is often withdrawn and lethargic and does not eat or sleep well. Which action should the nurse take after finding that the child is underweight and small for its age?
A) Give the baby medicine for colic
B) Draw blood for laboratory work
C) Feed the baby
D) Observe interactions between the parents and the infant
Answer: D
Explanation: A) The physician orders medications.
B) The physician orders laboratory tests.
C) Assessment is the priority, not feeding the baby.
D) Because the parents' concerns and nurse's observations are possibly related to failure to thrive, the nurse would assess the relationship and interactions between the infant and the parents.
Page Ref: 1889
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.D. Analyze failure to thrive as it relates to development. Apply the nursing process in providing culturally competent care to an individual with failure to thrive.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with failure to thrive.

5) The nurse suggests that the mother of an infant with failure to thrive (FTT) see a lactation specialist to assist with breastfeeding. Which goal is appropriate when planning care for this family?
A) Increase the number of well-child checkups for the child.
B) Convince the mother to use formula instead of continuing with breastfeeding.
C) Improve the parent-child relationship.
D) Prevent complications associated with poor nutrition.
Answer: D
Explanation: A) Increasing the number of checkups will not improve nutrition.
B) If the mother wishes to continue breastfeeding and help can be obtained, it may be harmful to her self-esteem to insist she bottle feed the infant, although supplementation with formula is an option.
C) There is no evidence that the mother is not relating well to the child.
D) The goal is to prevent complications associated with poor nutrition.
Page Ref: 1889
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 25.D. Analyze failure to thrive as it relates to development. Apply the nursing process in providing culturally competent care to an individual with failure to thrive.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with failure to thrive.

6) The nurse is teaching a mother of an infant with failure to thrive (FTT) about the treatment for the condition. Which statement by the nurse is appropriate?
A) "Appetite stimulant medications will be prescribed to help your child gain weight."
B) "If your child is breastfeeding, you must stop and feed your child formula."
C) "A home care nurse will be visiting to see how your child eats."
D) "A home care nurse will be visiting to insert a nasogastric feeding tube in your child."
Answer: C
Explanation: A) No specific pharmacologic therapy is indicated with FTT.
B) A woman who is breastfeeding a child with FTT does not need to stop breastfeeding. The mother should be provided teaching about proper breastfeeding techniques and additional information as needed.
C) Teaching the child's parent is paramount in the treatment for a child with FTT. A home care nurse may visit the child's home to observe how the child eats in order to teach the child's parent about any barriers or techniques to improve nutrition.
D) A child with FTT does not automatically require a nasogastric tube for enteral feedings.
Page Ref: 1889
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.D. Analyze failure to thrive as it relates to development; 25.D.5. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with failure to thrive.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with failure to thrive.

7) The nurse is caring for an older adult who has been losing weight. Which finding would the nurse expect if the client has geriatric failure to thrive (GFTT)?
A) Decreased salivation and slowed gastrointestinal (GI) motility
B) Neurologic disease or condition
C) Excessive caloric expenditure
D) Congenital errors of metabolism
Answer: A
Explanation: A) Age-related changes impact food intake and digestion and can lead to GFTT, including decreased sense of taste, decreased secretion of digestive enzymes, and decreased salivation. GI motility also slows with age, decreasing metabolism.
B) Neurologic diseases or conditions can lead to either FTT or GFTT.
C) Excessive caloric expenditure can lead to GFTT.
D) Congenital errors of metabolism often cause FTT, not GFTT.
Page Ref: 1886
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 25.D. Analyze failure to thrive as it relates to development. Describe the etiology of failure to thrive.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with failure to thrive.

8) The nurse is reviewing the pathophysiology of geriatric failure to thrive (GFTT). Which statement *best* describes the relationship of nutrition, immunity, and geriatric failure to this condition?
A) Illness leads to decreased appetite, which leads to decreased nutrition. This leads to decreased ability to recover from illness. Illness increases susceptibility to GFTT.
B) Decreased nutrition leads to increased appetite. If appetite is so great that it cannot be satiated, GFTT develops. Once GFTT develops, risk of illness and infection increases.
C) Decreased appetite leads to decreased nutrition. This leads to decreased ability to recover from infection, which increases susceptibility to illness. Illness increases susceptibility to GFTT.
D) GFTT leads to decreased appetite. This leads to imbalanced nutrition and increased susceptibility to illness. This increases the likelihood that GFTT will become chronic.
Answer: C
Explanation: A) Illness, in turn, makes patients more susceptible to GFTT.
B) Decreased nutrition does not cause an increase in appetite in all people.
C) Anorexia of aging is a decrease in appetite and consequential decrease of nutrition intake. Vitamin and nutrient deficiencies are also common, and decrease older patients' ability to recover from injury, illness, and infection. This impaired immunity makes older patients more susceptible to both chronic and acute illnesses; illness, in turn, makes patients more susceptible to GFTT.
D) A change in appetite does not always lead to chronic GFTT.
Page Ref: 1886
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 25.D. Analyze failure to thrive as it relates to development. Describe the etiology of failure to thrive.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with failure to thrive.

9) A baby is diagnosed with an inorganic cause of failure to thrive (FTT). In which way should the nurse explain this condition to the parents?
A) The FTT is not the result of a disease process or medical condition.
B) The FTT is the result of inborn errors in metabolism.
C) The FTT is the result of congenital disease.
D) The FTT is the result of a congenital anomaly such as cleft palate.
Answer: A
Explanation: A) Most cases of FTT are nonorganic in origin, meaning they are not the result of a disease process or medical condition. FTT resulting from nonorganic causes is called feeding disorder of infancy or early childhood.
B) Organic causes of FTT include inborn errors of metabolism.
C) Organic causes of FTT include congenital diseases.
D) Organic causes of FTT include cleft palate.
Page Ref: 1886
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 25.D. Analyze failure to thrive as it relates to development. Describe the etiology of failure to thrive.
MNL LO: Demonstrate understanding of the concept of development in the care of a patient with failure to thrive.

10) The nurse is caring for a pregnant client who has a history of depression. For which reason will the nurse provide information to decrease the client's risk for having an infant with failure to thrive (FTT)?

A) Women with mental illness have a decreased breastmilk supply, increasing the risk of FTT.

B) Women with mental illness may be socially isolated, increasing the risk of FTT.

C) Women with mental illness take medications that pass through the breastmilk, increasing the risk of FTT.

D) Women with mental illness lack the knowledge required to provide adequate nutrition, increasing the risk of FTT.

Answer: B

Explanation: A) Women with mental illness do not have a decreased breastmilk supply, increasing the risk of FTT.

B) Women with mental illness may be socially isolated, increasing the risk of FTT.

C) Medications passing through the breastmilk does not increase the risk of FTT.

D) It is not true that women with mental illness lack the knowledge to provide nutrition and increase the risk of FTT.

Page Ref: 1887

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 25.D. Analyze failure to thrive as it relates to development. Compare the risk factors and prevention of failure to thrive.

MNL LO: Demonstrate understanding of the concept of development in the care of a patient with failure to thrive.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 26 Family

The Concept of Family

1) The nurse is caring for a preschool-age client who was admitted for dehydration. The child lives with the parents and maternal grandparents. In which type of family does this child reside?
A) Blended family
B) Extended family
C) Two-career family
D) Nuclear family
Answer: B
Explanation: A) A blended family occurs when existing family units join together to form new families.
B) In some cultures, and as people live longer, more than two generations may live together in an extended setting.
C) A two-career family is one where both partners are employed.
D) A nuclear family is viewed as an autonomous unit in which both parents reside in the home.
Page Ref: 1897
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 26.1. Outline the makeup of the family structure.
MNL LO: Analyze the concept of family and its application to nursing care.

2) During a home visit, the nurse determines that care interventions are needed to address alcohol and substance abuse by family members. Which interventions should the nurse consider when planning care for this family? **Select all that apply.**

A) Suggest grief counseling.

B) Evaluate family members' potential for being a danger to self or others.

C) Suggest engaging in educational activities.

D) Be alert to behaviors that indicate sibling jealousy.

E) Recommend community resources to assist with substance abuse behavior.

Answer: B, E

Explanation: A) Grief counseling would be appropriate for the family who has suffered a loss of a family member.

B) For the family with alcohol or substance abuse, the nurse should evaluate family members' potential for being a danger to self or others.

C) Educational activities would be appropriate for the antepartum or postpartum family.

D) Being alert to sibling jealousy would be appropriate for the antepartum or postpartum family.

E) For the family with alcohol or substance abuse, the nurse should recommend community resources to family members to help with substance abuse behaviors.

Page Ref: 1908

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 26.5. Outline the relationship between family and other concepts.

MNL LO: Analyze the concept of family and its application to nursing care.

3) During a follow-up home visit, the nurse is evaluating the success of a family's ability to use internal resources to cope with the illness of a family member. Which observations by the nurse indicate that internal resources are being accessed? **Select all that apply.**

A) Next-door neighbor helping with family chores
B) Effective communication pattern
C) Skill in providing care to the ill family member
D) Church members stopping by with groceries
E) Center for Aging picking up the family member to transport to a physician's appointment

Answer: B, C

Explanation: A) External support systems promote coping and adaption and include friends.
B) Internal resources include effective communication patterns.
C) Internal resources include knowledge or skills to assist in the family problem-solving process.
D) External support systems promote coping and adaption and include religious affiliations.
E) External support systems promote coping and adaption and include community resources.

Page Ref: 1901
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies:. 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication.
Nursing Process Assessment

Learning Outcome: 26.4. Differentiate alterations in family.
MNL LO: Analyze the concept of family and its application to nursing care.

4) The nurse is making an initial visit to assess the parenting style of a family with a child who takes medications to reduce hyperactivity. Which approach should the nurse use for this assessment?
A) Ask the parents, "How do you handle situations that require limit setting?"
B) Ask the child, "What rule is hardest for you to obey?"
C) Observe the parent interacting with the child for 5 minutes.
D) Ask the parents, "What are the house rules?"
Answer: A
Explanation: A) Parental styles are best assessed while the family explains how it handles situations that require limit setting.
B) Asking the child which rule is hardest to follow will not give the nurse insight into parenting styles.
C) A less complete picture of parenting style is obtained during a brief artificial observation.
D) Learning about rules is less helpful than is an explanation of enforcement efforts and success.
Page Ref: 1902
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 26.6. Explain family health promotion.

MNL LO: Analyze the concept of family and its application to nursing care.

5) The nurse identifies that a family new to the community needs assistance with family dynamics and material resources. Which recommendations should the nurse make to the parents to support their needs? **Select all that apply.**
A) A list of free counseling services to assist with parental stress
B) Hours of the local health clinic
C) Location of the community library
D) Location of the community co-op food bank
E) Hours when the park is open
Answer: A, B, D
Explanation: A) For families in need of counseling, financial assistance may be available.
B) Families facing economic challenges should be made aware of community resources, including wellness clinics.
C) The hours for the library would not help the family with the issues that the nurse observed.
D) Families facing economic challenges should be made aware of community resources, including food banks.
E) The hours for the park would not help the family with the issues that the nurse observed.
Page Ref: 1909
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.8 Promote self-care management. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 26.8. Analyze independent interventions nurses can implement for patients with alterations in family.
MNL LO: Analyze the concept of family and its application to nursing care.

6) The nurse is preparing a community program about health promotion and disease prevention. Which activities should the nurse include? **Select all that apply.**

A) Helping a mother determine a daily feeding schedule for her infant

B) Teaching a school-age child how to use dental floss

C) Teaching parents how to perform pulmonary drainage and cupping on their ill child

D) Treating a child diagnosed with pneumonia

E) Administering the flu vaccine for an infant who is 9 months of age

Answer: A, B, E

Explanation: A) Discussing feeding schedules is a health promotion and/or maintenance topic.

B) Instructing children about the use of dental floss is a health promotion and/or maintenance topic.

C) Teaching parents how to perform pulmonary drainage and cupping on their ill child is not considered health promotion and maintenance because it is treatment for acute illness.

D) Treatment of pneumonia would not be a topic for health promotion and maintenance, as pneumonia is an acute illness.

E) Administering flu vaccines is a health promotion and/or maintenance topic.

Page Ref: 1907

Cognitive Level: Analyzing

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 26.6. Explain family health promotion.

MNL LO: Analyze the concept of family and its application to nursing care.

7) The nurse is determining psychosocial risk factors for a family prior to planning care. Which assessment tool should the nurse use when screening a family for health risks?
A) Friedman Family Assessment Tool
B) Family Ecomap
C) Home Observation for Measurement of the Environment (HOME)
D) Family APGAR
Answer: D
Explanation: A) The Friedman Family Assessment tool is not appropriate for initial family assessments.
B) The Family Ecomap is not appropriate for initial family assessments.
C) The Home Observation for Measurement of the Environment is not appropriate for initial family assessments.
D) The Family APGAR is a quick five-item questionnaire that may be used as an initial screening tool for family assessment.
Page Ref: 1911
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 26.6. Explain family health promotion.

MNL LO: Analyze the concept of family and its application to nursing care.

8) The nurse is observing a family counseling session that is focusing on the family members' communication patterns. Which observation indicates that there are existing or potential problems with family communication?
A) All members are participating in the discussion equally.
B) A few of the members just sit and listen.
C) Disagreements are ignored by the family leader.
D) The verbal communication is congruent with the nonverbal messages.
Answer: C
Explanation: A) Even though some members are more vocal, at least all are participating in the discussion.
B) Listening is an art, and not all members of a family need to speak in the same setting.
C) An authoritarian setting is one in which one or more members set firm, nonnegotiable limits and other members may be cautious in expressing their feelings because of power struggles, hostility, or anger. Nurses should pay special attention to who does the talking for the family, which members are silent, how disagreements are handled, and how well the members listen to one another and encourage the participation of others.
D) Verbal communication should be congruent with nonverbal cues.
Page Ref: 1903
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 26.9. Summarize collaborative therapies used by interprofessional teams for clients with alterations in family.
MNL LO: Analyze the concept of family and its application to nursing care.

9) The nurse in an outpatient pediatric clinic notes that a preschool-aged child who needs vaccinations was due to be seen but is a no-show. Which action should the nurse take?
A) Call the parents and encourage them to bring the child for recommended care.
B) Speak firmly with the parents about the importance of being compliant.
C) Notify the healthcare provider that the child's immunizations are no longer up to date.
D) Plan to discuss the principles of health supervision at the next scheduled visit.
Answer: A
Explanation: A) The nurse in the pediatric healthcare setting is responsible for reviewing the health supervision of the child. Partnering with the parents and encouraging the parents to follow health-supervision guidelines are the best strategies to use.
B) Speaking firmly with the parents about compliance will alienate the parents at this time.
C) Discussing with the healthcare provider that the immunizations are not up to date is not necessary in an outpatient clinic. Immunizations are given per schedule.
D) A discussion of the principles of health supervision without an intervention at this visit would mean a delay in needed healthcare for the child in this example.
Page Ref: 1907
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 26.6. Explain family health promotion.
MNL LO: Analyze the concept of family and its application to nursing care.

10) The nurse is planning a wellness seminar for families in an urban community. Which resources should the nurse consider obtaining to support these families' needs? **Select all that apply.**
A) Emergency first responder personnel
B) Information about community healthcare providers
C) Individuals who provide mental health services
D) Law enforcement officials
E) Nutritionists
Answer: B, C, E
Explanation: A) Ambulance first responders will not necessarily support the goal of the wellness program.
B) Educating clients about community service providers will improve the family's quality of life and reduce the risk of illness.
C) Depending on the needs of the client, nurses may collaborate with mental health specialists.
D) Law enforcement personnel will not necessarily support the goal of the wellness program.
E) Educating clients and facilitating appropriate referrals to nutritionists will not only improve the family's quality of life, but also reduce the risk of illness.
Page Ref: 1907, 1909
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.8 Promote self-care management. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
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Learning Outcome: 26.9. Summarize collaborative therapies used by interprofessional teams for patients with alterations in family.
MNL LO: Analyze the concept of family and its application to nursing care.

11) The nurse is evaluating the success of wellness care provided to a new family in the community. Which observations by the nurse indicate that care has been successful? **Select all that apply.**
A) The children are observed eating doughnuts for breakfast.
B) All family members have up-to-date immunizations.
C) The family spends every Saturday afternoon participating in physical activities.
D) The youngest child squints when reading school work.
E) The oldest child does not wash his hands before eating.
Answer: B, C
Explanation: A) Eating doughnuts for breakfast could indicate poor nutrition.
B) Evaluation of care is based on the family's progress toward goals and outcomes mutually determined by the family and nurse. Examples of achieved outcomes include each family member is up to date with all vaccinations.
C) Evaluation of care is based on the family's progress toward goals and outcomes mutually determined by the family and nurse. Examples of achieved outcomes include family members demonstrate more frequent engagement in activities that involve the entire family unit.
D) Squinting when reading indicates the need for a vision assessment.
E) Not washing hands before eating could lead to the ingestion of a microorganism that could cause disease.
Page Ref: 1909
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 26.6. Explain family health promotion.
MNL LO: Analyze the concept of family and its application to nursing care.

WwW.TeSt-Ws

12) A parent consoles and comforts a school-age child after the child had a fight with another playmate. Which family role is the parent assuming?

A) Maintaining the continuity of society by transmitting knowledge and beliefs to children
B) Caring, nurturing, and educating children
C) Receiving and giving love
D) Meeting the protection and economic support needs of family members

Answer: B

Explanation: A) Maintaining continuity of society involves the transmission of customs and traditions on a cultural level.

B) Caring, nurturing, and educating children involves teaching children how to get along in the world.

C) While the interaction shows the parent expressing love for the child this is not its primary focus.

D) Protection and economic support involve meeting physical needs for shelter and nutrition.

Page Ref: 1901
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | Nursing Process: Assessment
Learning Outcome: 26.1. Outline the makeup of the family structure.
MNL LO: Analyze the concept of family and its application to nursing care.

13) A nuclear family has three children–an infant who is 18 months old, a preschooler who is 4 years old, and a first grader who is 7 years old. According to Duvall's eight-stage family life cycle, in which stage is this family functioning?
A) Stage I
B) Stage II
C) Stage III
D) Stage IV
Answer: D
Explanation: A) Stage I is a couple that does not yet have children.
B) Stage II is a family whose oldest child is up to 30 months of age.
C) Stage III is a family whose oldest child is in preschool.
D) The oldest child serves as a marker for the family's developmental stage. In this case, the family is in stage IV, which is characterized by having school-aged children.
Page Ref: 1899
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 26.1. Outline the makeup of the family structure.
MNL LO: Analyze the concept of family and its application to nursing care.

WwW.TeSm.Ws

14) The mother of a nuclear family works at home and is the primary caregiver for one kindergarten-aged child while the father is out of town for work most months of the year. In which way will this family situation impact cohesion?
A) Disengaged triadic between all three members.
B) Cohesive dyadic between the mother and father.
C) Cohesive dyadic between the mother and child.
D) Cohesive triadic between all three members.
Answer: C
Explanation: A) The mother and child will become less dependent on the father, making triadic (three-person) dynamics less likely.
B) The mother is less likely to have a strong dyadic relationship with the father during this time.
C) With the father absent, the dynamics will likely become dyadic (two-person) between the mother and child as they come to depend on each other more.
D) The mother and child will become less dependent on the father, making triadic (three-person) dynamics less likely.
Page Ref: 1901
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | Nursing Process: Assessment
Learning Outcome: 26.2. Summarize the factors that shape family development.
MNL LO: Analyze the concept of family and its application to nursing care.

Exemplar 26.A Family Response to Health Alterations

1) The nurse is assigned to care for a child in a spica cast for a fractured femur suffered in an automobile accident. The child's father was driving the car, which was badly damaged. In assessing the family, the nurse learns that the father just recently lost his job and the mother has been working through a "temp" agency. Which problem is most appropriate for this family?
A) Caregiver burden
B) Inadequate parenting
C) Impaired family functioning
D) Inadequate family skills or resources
Answer: C
Explanation: A) There is no evidence of a caregiver burden.
B) There is no evidence of inadequate parenting.
C) The family is experiencing impaired family functioning because of the multiple changes that have occurred in a short time with this family.
D) There is no evidence of inadequate family skills or resources.
Page Ref: 1923
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | Nursing Process: Diagnosis
Learning Outcome: 26.A. Analyze family response to health alterations. Apply the nursing process in providing culturally competent care to families with health alterations.
MNL LO: Analyze the concept of family and its application to nursing care.

WwW.TeSt-Ws

2) A client with a bipolar disorder arrives at the emergency department disheveled, arguing with family members. For which reason should the nurse suspect that the family is experiencing an objective caregiver burden?
A) The client's symptomatic behaviors
B) Family conflict
C) Anger
D) Caregiving problems
Answer: A
Explanation: A) Objective caregiver burdens are those that are measurable, such as disruption of family functioning and routines and financial costs of care.
B) The family may be experiencing family conflict, but this is because of the client's symptomatic behaviors.
C) The family may be experiencing anger, but this is because of the client's symptomatic behaviors.
D) The family may be experiencing caregiving problems, but this is because of the client's symptomatic behaviors.
Page Ref: 1918
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 26.A. Analyze family response to health alterations. Identify the clinical manifestations of family response to health alterations.
MNL LO: Analyze the concept of family and its application to nursing care.

3) The nurse is caring for a client with two teenage children whose spouse was killed in a motor vehicle crash. Which statement explains how this tragedy will be approached by the family?
A) The family feels that their place in the community has been eliminated.
B) Family members may become detached from extended family.
C) Family function will be impaired.
D) The family may withdraw into seclusion during the grief process.
Answer: C
Explanation: A) There is no reason for the family's place in the community to be eliminated.
B) There is no reason for the family to become detached from extended family members.
C) The death of a family member often has a profound effect on the whole family–especially if the deceased was the head of the family. Family function will be impaired until the family begins to recover, a new sense of normalcy develops, and the family reintegrates its roles and functions.
D) There is no reason for the family to withdraw into seclusion during the grieving process.
Page Ref: 1923
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 26.A. Analyze family response to health alterations. Describe the impact of illness on the family system.
MNL LO: Analyze the concept of family and its application to nursing care.

4) The nurse is caring for a client who is hospitalized with pneumonia. Which characteristics will the nurse assess when determining the impact of the illness on the family? **Select all that apply.**
A) The duration of the illness
B) The effect of the illness on future family functioning
C) The cause of the illness
D) The meaning of the illness to the family
E) The financial impact of the illness
Answer: A, B, D, E
Explanation: A) The impact on the family is assessed by the duration of the illness.
B) The impact on the family is assessed by the effect on family functioning.
C) The cause of the illness is not a factor that determines the impact on the family.
D) The impact on the family is assessed by the meaning of the illness to the family.
E) The impact on the family is assessed by the effect on the family finances.
Page Ref: 1917
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | Nursing Process: Assessment
Learning Outcome: 26.A. Analyze family response to health alterations. Describe the impact of illness on the family system.
MNL LO: Analyze the concept of family and its application to nursing care.

5) The nurse is creating a plan of care for the family of a client with a terminal illness. Which aspects of this family's care should the nurse emphasize when creating this plan? **Select all that apply.**

A) Instructing on medication administration
B) Guiding to determine realistic goals
C) Identifying strategies to enhance family functioning
D) Suggesting that cultural practices be minimized at this time
E) Focusing on the client's health needs as a priority

Answer: B, C

Explanation: A) Teaching medication administration is an intervention that would support the assimilation of the ill client back into the home and family environment.
B) Nursing care includes assisting the family with planning realistic goals/outcomes.
C) Nursing care includes assisting the family with strategies that enhance family functioning, such as improving communication skills, and identifying and using support systems.
D) The nursing care should incorporate cultural practices and not minimize them.
E) The family's needs are as important as those of the client and need to be addressed by the nurse.

Page Ref: 1919
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 26.A. Analyze family response to health alterations. Outline aspects of collaboration necessary to the care of families experiencing health alterations.
MNL LO: Analyze the concept of family and its application to nursing care.

6) The sibling of an adolescent with depression reports being tired from having to do extra chores and does not like how the parents' behavior has changed. Which type of family burden is the patient's sister experiencing?
A) A low level of subjective burden
B) A high level of subjective burden
C) A low level of objective burden
D) A high level of objective burden
Answer: B
Explanation: A) The sibling would not be tired if there was a low-level of subjective burden.
B) Subjective burden refers to a family member's perception of what is burdensome. In this case, the sibling is upset because of having to do extra chores and seeing a change in the parents' behavior.
C) Objective burdens are those that are measurable, such as cost of care.
D) Objective burdens are those that are measurable, such as cost of care.
Page Ref: 1918
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 26.A. Analyze family response to health alterations. Describe the impact of illness on the family system.
MNL LO: Analyze the concept of family and its application to nursing care.

7) The nurse is asked to review policies that encourage families to participate in the care of children. Which statement meets this goal?

A) "Parents are welcome to remain in their child's room overnight if they wish."
B) "Hospital policies require that patients eat food prepared onsite."
C) "Sibling visits are allowed between the hours of 8 a.m. and 6 p.m."
D) "Comfort items from home are not permitted without the approval of the nursing staff."

Answer: A

Explanation: A) Words like *guidelines, working together,* and *welcome* communicate openness and appreciation for families in the care of their children.

B) Words like *policies, allowed,* and *not permitted* imply that hospital personnel have authority over families in matters concerning their children.

C) Words like *policies, allowed,* and *not permitted* imply that hospital personnel have authority over families in matters concerning their children.

D) Words like *policies, allowed,* and *not permitted* imply that hospital personnel have authority over families in matters concerning their children.

Page Ref: 1919-1920

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 26.A. Analyze family response to health alterations. Apply the nursing process in providing culturally competent care to families with health alterations.

MNL LO: Analyze the concept of family and its application to nursing care.

8) The nurse at a gerontologist's office works with many older adult clients who are cared for by family members. Which care provider should the nurse identify as belonging to the "sandwich generation?"
A) A 72-year-old retired man who cares for his wife and the couple's pets
B) A 21-year-old man who cares for two grandparents between college classes
C) A 55-year-old single man who cares for his mother and maintains her home
D) A 40-year-old married woman who cares for her mother and her two teenage children
Answer: D
Explanation: A) Caring for pets is not considered being a member of the sandwich generation.
B) Caring for grandparents between college classes is not considered being a member of the sandwich generation.
C) Caring for a parent is not considered being a member of the sandwich generation.
D) Adults who care for their own children and one or more of their own aging parents belong to a group that has come to be known as the "sandwich generation." This group faces an incredible amount of stress trying to meet the diverse needs of young children and adolescents as well as aging parents.
Page Ref: 1921
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 26.A. Analyze family response to health alterations. Apply the nursing process in providing culturally competent care to families with health alterations.
MNL LO: Analyze the concept of family and its application to nursing care.

9) The nurse notes that a genogram for a patient with a mental illness shows no history for mental health in previous generations. Which reason should the nurse suspect is the reason for this missing information?
A) Information from previous generations is not relevant to mental health.
B) Older generations may not willingly volunteer mental health information.
C) Mental illness was uncommon three or more generations ago.
D) Only information from a patient's parents and siblings is included in a genogram.
Answer: B
Explanation: A) A family genogram is helpful in collecting information, as detailed health histories should incorporate data regarding the patient's parents, siblings, grandparents, and even great-grandparents if information is available.
B) When assessing a family's history of mental illness, nurses should be aware that many individuals from older generations may not volunteer knowledge about their mental illness.
C) Mental illnesses were common in previous generations.
D) A family genogram is helpful in collecting information, as detailed health histories should incorporate data regarding the patient's parents, siblings, grandparents, and even great-grandparents if information is available. If aunts, uncles, or cousins have had any health concerns, these should be noted as well.
Page Ref: 1923
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 26.A. Analyze family response to health alterations. Apply the nursing process in providing culturally competent care to families with health alterations.
MNL LO: Analyze the concept of family and its application to nursing care.

10) The nurse is preparing a teaching tool about mental illness. Which statement describes the family burden associated with mental illness?
A) It is the overall level of distress experienced as a result of the mental illness.
B) It is the pattern of negative attitudes that lead people to fear individuals with mental illness.
C) It is the measurable or quantifiable impacts of mental illness on the family.
D) It is the assessment that visualizes the way the family interacts with the community.
Answer: A
Explanation: A) Family burden is the overall level of distress experienced in the family as a result of the mental illness.
B) Stigma is the pattern of negative attitudes that lead people to fear and discriminate against individuals with mental illness and their families.
C) Objective burdens are a type of family burden that is measurable or quantifiable.
D) An ecomap is an assessment tool that helps nurses visualize how the family unit interacts with the external community environment.
Page Ref: 1918
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 26.A. Analyze family response to health alterations. Apply the nursing process in providing culturally competent care to families with health alterations.
MNL LO: Analyze the concept of family and its application to nursing care.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 27 Grief and Loss

The Concept of Grief and Loss

1) The nurse is preparing to assess a client whose spouse died several weeks ago. Which symptoms is the nurse most likely to observe in the client as part of the classic grief response? **Select all that apply.**
A) Weight loss
B) Frequent headaches
C) Difficulty sleeping
D) Excessive energy
E) Increased appetite
Answer: A, B, C
Explanation: A) Biological responses to grief include weight loss.
B) Somatic complaints associated with grief include frequent headaches.
C) Biological responses to grief include sleep disturbances.
D) Clients who are experiencing grief often report intermittent periods of decreased energy.
E) Biological responses to grief include decreased appetite.
Page Ref: 1927
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 27.1. Analyze the process of grieving.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

2) The partner of a client who just died due to an intentional drug overdose is somber and dry-eyed. Which factor should the nurse suspect is causing the partner's behavior?
A) The partner is waiting to grieve until the client's family can join him.
B) The partner is seeking support from staff members on the unit.
C) The partner anticipates that others will find the client's actions socially unacceptable.
D) The partner is concerned that others may view showing emotion as weakness.
Answer: C
Explanation: A) It is unlikely that the partner is waiting for the family to grieve.
B) It is unlikely that the partner is seeking support from the staff.
C) The partner may be experiencing disenfranchised grief, which occurs when individuals cannot acknowledge their loss to others. Disenfranchised grief is more common in situations in which the loss is considered socially inappropriate or unacceptable, such as the loss of someone from suicide or a drug overdose.
D) It is unlikely that the partner is concerned about appearing weak.
Page Ref: 1928
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 27.1. Analyze the process of grieving.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

3) The nurse is planning care for a group of clients who are experiencing grief. Which principle from accepted grief models should the nurse use to guide care?
A) No clear timetables for grief exist, nor are there clear-cut stages of grief.
B) There is strong research evidence indicating that these models are not useful for many dying clients.
C) These models serve as clear and definitive predictors of grief behaviors.
D) The Kübler-Ross model is primarily used to describe anticipatory grief.
Answer: A
Explanation: A) Although models of grief are useful in guiding the nursing care of clients who are experiencing loss, there are no clear-cut stages of grief, nor are there exact timetables.
B) No research exists that proves these models are not useful.
C) None of these models clearly or definitively predict grief behaviors.
D) The Kübler-Ross model describes all stages of grief and grieving, not just anticipatory grief.
Page Ref: 1928
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 1.2 Apply theory and research-based knowledge from nursing, the arts, humanities, and other sciences. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 27.1. Analyze the process of grieving.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

4) During a home care visit, an older adult client states to the nurse, "My spouse died 3 years ago." Which action is a possible indicator that the client is experiencing complicated grief?
A) The client says the spouse was an awful cook and meals have been better since the death.
B) The client hasn't seen the doctor since the spouse died because the doctor's office provides sad memories.
C) The client has an album of photographs of the spouse open on the living room table.
D) The client indicates that the laundry is sent out to be done because of not knowing how to work the washing machine.
Answer: B
Explanation: A) Talking about the deceased spouse's bad points is a normal response to grieving.
B) Refusing to go to the doctor's office for over 3 years is considered outside the normal limits of the grieving process for older adults.
C) Showing photographs of a deceased spouse is a normal response to grief.
D) Sending out the laundry is a healthy response to a problem that this client identified.
Page Ref: 1928
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 27.1. Analyze the process of grieving.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

5) The nurse is caring for a client with complicated grieving after the loss of a child. Which treatment approaches does the nurse anticipate being included in the collaborative plan of care for this client? **Select all that apply.**
A) Antidepressants
B) Electroconvulsive therapy
C) Talk therapies
D) Complicated grief treatment
E) Anger management
Answer: A, C, D
Explanation: A) The treatment for complicated grieving is similar to the treatment for depression. Antidepressants is a common treatment option.
B) Electroconvulsive therapy is typically reserved as a "last resort" treatment for severe depression or bipolar disorder, so it would not be included in an early plan of care.
C) The treatment for complicated grieving is similar to the treatment for depression. Talk therapies are common treatment options.
D) Complicated grief treatment is a form of psychotherapy given over 16 sessions that is proven to be effective.
E) The description does not indicate that the client has a problem with anger management.
Page Ref: 1937
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 27.6. Summarize collaborative therapies used by interprofessional teams for patients experiencing grief and loss.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

6) A client whose partner died a few weeks ago is unable to openly grieve because the partner was married and no one was aware of the relationship. For which type of grief should the nurse plan care for this client?

A) External grief
B) Chronic grief
C) Abbreviated grieving
D) Disenfranchised grieving

Answer: D

Explanation: A) External grieving is not a recognized type of grief response.
B) This client's grief is not yet chronic, as only a few weeks have passed.
C) Abbreviated grieving is grieving that is brief but genuinely felt.
D) This client is likely experiencing the form of grief known as disenfranchised grieving, which occurs when individuals cannot acknowledge their loss to others. Disenfranchised grieving is common in situations where the loss is not socially recognized, as is the case with this client, because extramarital affairs are not socially sanctioned.

Page Ref: 1928
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 27.1. Analyze the process of grieving.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

7) The nurse is concerned that a client whose spouse died 2 years ago is experiencing complicated grief. Which interventions should the nurse consider when planning care for this client? **Select all that apply.**

A) Monitoring for suicidal behavior

B) Psychotherapy

C) Substance abuse assessment

D) Alcohol abuse assessment

E) Hypnosis

Answer: A, B, C, D

Explanation: A) Nursing care for the client with complicated grief includes monitoring for suicidal behaviors.

B) Nursing care for the client with complicated grief includes psychotherapy.

C) Nursing care for the client with complicated grief includes assessment for signs of substance abuse.

D) Nursing care for the client with complicated grief includes assessment for signs of alcohol abuse.

E) There is no evidence that the client would benefit from hypnosis.

Page Ref: 1930

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 27.6. Summarize collaborative therapies used by interprofessional teams for patients experiencing grief and loss.

MNL LO: Analyze the concept of grief and loss and its application to nursing care.

8) A client is hospitalized for suicidal ideations as a response to complicated grief. Which collaborative interventions can the nurse anticipate including in this client's care? **Select all that apply.**

A) Social service consult
B) Bereavement group
C) Antidepressant medication
D) Sleep medication
E) Psychotherapy

Answer: A, B, C, E

Explanation: A) Collaboration may also include requesting a referral to a social worker who can provide expert guidance about coping with loss or assist with linking clients with additional resources.

B) Bereavement groups can be a resource for clients who have experienced a loss.

C) Treatment for complicated grief may include antidepressants.

D) Although impaired sleep patterns may be associated with grieving, medications to promote sleep usually are not indicated for these clients.

E) Treatment for complicated grief often involves a form of psychotherapy, which may be used in combination with antidepressants.

Page Ref: 1936-1937
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 27.6. Summarize collaborative therapies used by interprofessional teams for patients experiencing grief and loss.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

9) The adolescent child of a recently deceased patient is quiet and does not talk about the loss. Which action by the nurse is appropriate to assist the adolescent?

A) Ask the doctor to prescribe a sedative for the adolescent.
B) Ask the adolescent if any friends are available to talk.
C) Provide the adolescent with paper, pens, and pencils.
D) Notifying the hospital chaplain to come talk with the adolescent.

Answer: B

Explanation: A) Asking the doctor to prescribe a sedative will only delay the grieving process.
B) Adolescent grief responses are very similar to those of most adults, and they may display a wide range of emotions, including depression, denial, and anger. Adolescents should be encouraged, but not forced, to voice their feelings about the loss. Sometimes individuals in this age group feel more comfortable talking to peers or those outside the family.
C) Providing paper, pens, and pencils is more appropriate for younger children dealing with grief and loss.
D) Calling the chaplain is an option, but it would be better if the adolescent were given a choice.

Page Ref: 1939
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 27.7. Differentiate considerations related to the assessment and care of children who are dying or experiencing significant loss.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

10) The community nurse is developing a seminar to help children who have experienced a loss. Which information should the nurse include to help these children adapt?
A) Explain that magical thinking helps with the pain.
B) Remind the child that big children don't cry.
C) Help create new memories.
D) Pretend that the individual has not really gone.
Answer: C
Explanation: A) Adults should not encourage magical thinking.
B) Adults should encourage children to express their emotions, not tell them not to cry.
C) Adults can help children adapt to a loss by listening, helping the child adjust to changes in routines, and encouraging activities that promote new memories.
D) Adults should reinforce that the beloved individual is not returning, and not pretend that the individual is not really gone.
Page Ref: 1938
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 27.7. Differentiate considerations related to the assessment and care of children who are dying or experiencing significant loss.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

11) The mother of a 3-year-old client was killed in an accident, and the client recently learned of the parent's death. Which nursing intervention would be most appropriate to support the developmental needs of this client?
A) Work with the surviving family members to ensure that the client's routine remains as normal as possible after release from the hospital.
B) Do not correct the client when she expresses the belief that the parent will "wake up and come home."
C) Provide the client with the same level of reassurance and attention as any other client on the unit.
D) Avoid answering the client when she asks questions about her mother's death.
Answer: A
Explanation: A) For grieving clients between the ages of 2 and 4, caregivers should to try to maintain as normal a routine as possible.
B) It is important to provide honest answers to questions about grief when they are asked.
C) Children in this age range will also benefit from extra reassurance and attention.
D) It is important to provide honest answers to questions about grief when they are asked.
Page Ref: 1938
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 27.7. Differentiate considerations related to the assessment and care of children who are dying or experiencing significant loss.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

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12) The nurse is providing counseling to the family of a terminally ill client who has siblings of varying ages. Which statement regarding the reactions of children to death is appropriate for the nurse to include in the counseling session?
A) "Older school-age children begin to understand that death is irreversible."
B) "Adolescents tend to cope better with death than adults."
C) "Preschool children view death as a spiritual release."
D) "Toddlers are able to fully comprehend the ideas related to death."
Answer: A
Explanation: A) At about age 8, a child's concept of death matures, and most understand that death is irreversible and that the individual is gone and will not be coming back.
B) Adults generally cope better with death than adolescents.
C) Preschoolers view death as reversible.
D) Toddlers are not able to fully comprehend ideas related to death.
Page Ref: 1938
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 27.7. Differentiate considerations related to the assessment and care of children who are dying or experiencing significant loss.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

13) During a home visit, the nurse is concerned that an older adult with a terminal illness should be hospitalized; however, the family wants the client to stay home. Which action by the nurse is most appropriate?
A) Follow the decision of the family.
B) Call for an ambulance to transport the client to a hospital.
C) Ask the client's preference regarding transport to the hospital.
D) Encourage the family to take the client to the hospital.
Answer: C
Explanation: A) The nurse would not follow the family's wishes without finding out what the client wants.
B) Calling for an ambulance is inappropriate.
C) The nurse should ascertain that this is what the client wishes and respect that.
D) Encouraging the family to take the client to a hospital is against their wishes.
Page Ref: 1932
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 27.9. Differentiate considerations related to the assessment and care of older adults experiencing a significant loss.

MNL LO: Analyze the concept of grief and loss and its application to nursing care.

14) An older adult whose spouse died 4 years ago has not made changes in the home and states that caring for the spouse was the client's sole purpose in life. For which condition should the nurse plan care for this client?
A) Anticipatory grieving
B) Self-care deficit in the area of feeding
C) Prolonged grief disorder
D) Death anxiety
Answer: C
Explanation: A) Anticipatory grieving occurs prior to a loss, which is not the case in this scenario.
B) This situation does not indicate that the client is having self-care problems in the area of feeding.
C) Prolonged grief disorder is grieving that continues more than 6 months after a loss and involves extreme distress, significant functional impairment, and, in some cases, suicidal ideation. This client's comments are suggestive of all these characteristics.
D) Death anxiety is associated with the anticipation of death–not with the period following death.
Page Ref: 1929
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 27.9. Differentiate considerations related to the assessment and care of older adults experiencing a significant loss.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

15) An older adult client whose spouse died 6 months ago tells the nurse stories about the deceased spouse because the client's children do not want to hear the stories. From which type of intervention would this client most likely benefit?
A) Antidepressant medication
B) Referral to a support group
C) Occupational therapy
D) Referral to a social worker
Answer: B
Explanation: A) Antidepressant medication is often used for depression or complicated grieving, and nothing in the above scenario suggests the client is affected by either of these conditions.
B) This client would most likely benefit from participation in a support group, which provides an environment in which to share stories, discuss concerns, and receive personal encouragement and support that may otherwise be lacking.
C) Occupational therapy would not be appropriate because the client is not describing problems in participating in activities of daily living.
D) Referral to a social worker is not necessary at this point, because nothing in the client's comments suggests the need for targeted social services.
Page Ref: 1930
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Communicate information effectively; listen openly and cooperatively. | Nursing Process: Planning
Learning Outcome: 27.9. Differentiate considerations related to the assessment and care of older adults experiencing a significant loss.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

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16) The nurse is caring for an older adult client who is experiencing grief after the recent loss of a spouse. Which behavior should the nurse anticipate with regard to the older adult's response to grief?
A) Grief in an older adult initially presents differently than in a younger adult.
B) Older adults may seem to experience the emotional aspects of grief more acutely than younger adults.
C) Manifestations of grief in older adults are usually less severe than those observed in younger clients.
D) Manifestations of grief in older adults are usually trust issues, suspecting once-close friends and family members of judging their pain or not understanding their emotions.
Answer: B
Explanation: A) Grief in an older adult initially presents similarly to that in a younger adult.
B) Older adults may seem to experience the emotional aspects of grief more acutely than younger adults.
C) Manifestations of grief in older adults are usually more profound than those observed in younger clients.
D) Complicated grief in the older adult manifests as trust issues; this is not a normal manifestation of grief in the older client.
Page Ref: 1946
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 27.9. Differentiate considerations related to the assessment and care of older adults experiencing a significant loss.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

17) The nurse is caring for an adolescent client who has just learned of being pregnant. Which assessment question is most appropriate to determine the client's risk for perinatal loss?
A) "At what age did you begin menstruating?"
B) "When was your last menstrual period?"
C) "Is this your first pregnancy?"
D) "Do you use any substances such as drugs, alcohol, or tobacco products?"
Answer: D
Explanation: A) Menstrual history is not related to the risk for perinatal loss.
B) Date of the last menstrual period is not related to the risk for perinatal loss.
C) A first pregnancy is not related to the risk for perinatal loss.
D) The use of drugs, alcohol, or tobacco is a risk factor for pregnancy complications and perinatal loss, so the client should be assessed for use of substances.
Page Ref: 1943
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Communicate information effectively; listen openly and cooperatively. | Nursing Process: Assessment
Learning Outcome: 27.8. Differentiate considerations related to the assessment and care of a family who experiences a perinatal loss.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

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18) The nurse is preparing to assess clients in the prenatal clinic. Which clients should the nurse identify as being at risk for prenatal loss? **Select all that apply.**
A) The woman who drinks one cup of coffee every morning
B) The woman recovering from a gastrointestinal virus
C) The unmarried 14-year-old girl living in the city
D) The woman who lacks access to health and prenatal care
E) The woman who had a healthy baby 6 months ago resulting from a healthy pregnancy
Answer: C, D, E
Explanation: A) One cup of coffee is not excessive intake of caffeine.
B) A gastrointestinal virus will not negatively impact the pregnancy.
C) Fetal mortality is highest in mothers who are earlier in their teens or unmarried.
D) Lack of access to healthcare and prenatal care, such as occurs in rural areas, may increase the risk of perinatal death.
E) Fetal mortality is highest in mothers with multiple pregnancies.
Page Ref: 1942
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.5. Examine common barriers to active involvement of patients in their own health care processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality & Safety: Communicate potential risk factors and actual errors. | Nursing Process: Assessment
Learning Outcome: 27.8. Differentiate considerations related to the assessment and care of a family who experiences a perinatal loss.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

19) The extended family of a client having labor induced because of fetal demise wants to be present for the delivery. Which action is most appropriate for the nurse to take in this situation?
A) Ask the client about her preferences regarding the family's request.
B) Call security to escort the family out of the hospital.
C) Speak with the nurse manager about supporting the family's wishes.
D) Show the family to the waiting room.
Answer: A
Explanation: A) The mother's preferences should determine how the delivery of a stillborn infant takes place; this includes who she wants in the birthing room with her.
B) Before confronting the family by calling security, the nurse should consult with the client.
C) If the client agrees to the extra visitors, then seeking the nurse manager's assistance is inappropriate.
D) Before confronting the family by asking them to leave the nurse should consult with the client.
Page Ref: 1945
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 27.8. Differentiate considerations related to the assessment and care of a family who experiences a perinatal loss.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

20) A client delivers a still born child at 36 weeks' gestation. Which intervention should the nurse perform to help the family grieve?
A) Remove all baby supplies from the mother's room.
B) Refrain from talking about the baby.
C) Facilitate and support the family viewing and holding the infant.
D) Ask to have the mother moved off the postpartum floor.
Answer: C
Explanation: A) Removing baby supplies might assist in the denial process.
B) Not talking about the baby reinforces denial of the death.
C) Advocates of seeing the stillborn believe that viewing assists in dispelling denial and allows the couple to take the next step in the grieving process.
D) The mother should be consulted before moving her off the postpartum unit.
Page Ref: 1945
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Respect the patient's dignity, uniqueness, integrity, and self-determination, and his or her own power and self-healing processes. | Nursing Process: Implementation
Learning Outcome: 27.8. Differentiate considerations related to the assessment and care of a family who experiences a perinatal loss.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

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21) The nurse is planning care for a client who is arriving on the unit with a suspected perinatal loss. Which nursing intervention is most appropriate in this situation?
A) Place the client in a room closest to the nurse's station to closely observe the client.
B) Call the hospital chaplain to ensure the chaplain can be in the client's room when the client arrives.
C) Call the local funeral home and notify them of the client's situation.
D) Place the client in the room farthest from the other clients.
Answer: D
Explanation: A) Placing the client near the nurse's station is not sensitive to the client's emotions.
B) The client should be asked if the chaplain is requested.
C) The family would contact the funeral home.
D) When planning care for a client with a suspected perinatal loss, the nurse should place the client in the room farthest from the other clients to provide for privacy.
Page Ref: 1945
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Respect the patient's dignity, uniqueness, integrity, and self-determination, and his or her own power and self-healing processes. | Nursing Process: Implementation
Learning Outcome: 27.8. Differentiate considerations related to the assessment and care of a family who experiences a perinatal loss.

MNL LO: Analyze the concept of grief and loss and its application to nursing care.

22) The nurse is planning care for a couple who has experienced a miscarriage. Which aspect of the grief response is essential for the nurse to anticipate?
A) The grief experienced by fathers after perinatal loss appears similar to the grief experienced by mothers after perinatal loss.
B) Postpartum depression may occur in women who have experienced perinatal loss.
C) Grief is typically less severe when the perinatal loss occurs before 20 weeks' gestation.
D) Perinatal loss refers only to emotional changes that occur after perinatal loss.
Answer: B
Explanation: A) The grief experienced by fathers after perinatal loss is less intense and occurs for a shorter duration than grief experienced by mothers.
B) Postpartum depression may occur in women who have experienced perinatal loss.
C) Grief can be mild to severe after perinatal loss, regardless of when the loss occurs.
D) Perinatal loss refers to the physical and emotional changes that occur after perinatal loss.
Page Ref: 1944
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Planning
Learning Outcome: 27.8. Differentiate considerations related to the assessment and care of a family who experiences a perinatal loss.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

23) A client experienced the loss of a spouse due to chronic illness, the loss of a grandchild due to stillbirth, and the loss of a long-time family pet, all within a 6-week period. Which type of loss is this client experiencing?
A) Caregiver loss
B) Cumulative loss
C) Compound loss
D) Complicated loss
Answer: B
Explanation: A) This type of loss is not called caregiver loss.
B) Cumulative loss is defined as several losses within a short period, one after another. The individual who experiences cumulative loss may not recover from the initial loss before the next loss occurs. Each loss has the potential to compound the grief of previous loss to the point where the individual becomes paralyzed with grief.
C) This type of loss is not called compound loss.
D) This type of loss is not complicated loss.
Page Ref: 1930
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 27.2. Analyze factors that affect the grieving process.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

24) A client is grieving after the loss of a job. Which pattern of behavior would be the nurse's priority concern?
A) Alcohol or substance use
B) Excessive sleeping
C) Overeating
D) Failing to exercise
Answer: A
Explanation: A) Alcohol and drug use can prolong the grieving process by masking the pain and delaying the work of grief. It can also quickly result in addiction, which further complicates the situation.
B) Excessive sleeping would be concerning; however, it is not as detrimental to the client as alcohol or substance use.
C) Overeating would be concerning; however, it is not as detrimental to the client as alcohol or substance use.
D) Failing to exercise would be concerning; however, it is not as detrimental to the client as alcohol or substance use.
Page Ref: 1931
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.5. Examine common barriers to active involvement of patients in their own healthcare processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Communicate information effectively; listen openly and cooperatively. | Nursing Process: Assessment
Learning Outcome: 27.2. Analyze factors that affect the grieving process.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

25) The nurse is caring for a client who found a loved one who committed suicide. In addition to the normal grief process, the nurse recognizes the client may be at risk for which other complication?
A) Seasonal affective disorder (SAD)
B) Posttraumatic stress disorder (PTSD)
C) Obsessive-compulsive disorder (OCD)
D) Major depressive disorder (MDD)
Answer: B
Explanation: A) The client may also be at higher risk for situational depression, but not usually SAD.
B) Clients who are exposed to trauma such as finding a loved one who has committed suicide are at increased risk for PTSD.
C) OCD is usually unrelated to grief or trauma.
D) The client may also be at higher risk for situational depression, but not usually MDD.
Page Ref: 1928
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 27.3. Outline the relationship between grief and loss and other concepts.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

26) The nurse is caring for a grieving family who is from another culture and has different religious beliefs. Which action should the nurse take to provide emotional support for this family?
A) Encourage the family to go eat a meal and come back to the hospital later.
B) Ask the physician to assess the family for ineffective coping.
C) Ask the family how the nurse can meet the family's cultural needs.
D) Refer the family to a group counseling session.
Answer: C
Explanation: A) The nurse should not encourage the family to go eat a meal without determining their cultural and religious needs first.
B) The nurse, not the physician, should assess the family for ineffective coping.
C) If the nurse is not familiar with the family's culture or religion, then the best way to support the family is to ask how the nurse can meet the family's cultural and religious beliefs.
D) The nurse should not refer the family to a group counseling session without determining their cultural and religious needs first.
Page Ref: 1932
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 27.3. Outline the relationship between grief and loss and other concepts.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

27) The nurse is caring for a family whose 8-year-old son recently died. Which question would best help the nurse assess this family's level of functioning?
A) "Have you returned to your normal schedule yet?"
B) "How have you expressed your feelings about the loss?"
C) "When do you think your grieving process will be complete?"
D) "Have any of you experienced prior loss?"
Answer: B
Explanation: A) At this point in the grieving process, it is insensitive and inappropriate to ask whether the family has returned to its "normal" daily schedule.
B) When assessing a grieving family's level of functioning, the nurse should inquire about the family's strengths, support systems, needs, perceptions of the coping process, and ways of expressing feelings about the loss.
C) It is impossible for a family to anticipate when its grieving process will be complete, so this question is inappropriate.
D) Although it can be helpful to ask whether any of the family members have experienced prior loss, this question will not provide the nurse with information about the family's current level of functioning.
Page Ref: 1934
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 27.4. Differentiate common assessment procedures used to examine patients or families who are grieving.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

28) The staff nurse is planning for a client who is grieving the loss of a spouse. Which action should the nurse identify as an appropriate independent nursing intervention?
A) Teach the client about the grieving process
B) Select an appropriate antidepressant
C) Conduct complicated grief therapy (CGT)
D) Provide chaplain services
Answer: A
Explanation: A) Interventions helpful in working with adults and older adults who are grieving include teaching the patient about the grieving process.
B) Selection of an appropriate antidepressant is a collaborative intervention.
C) Providing complicated grief counseling is a collaborative intervention.
D) Chaplain services is a collaborative intervention.
Page Ref: 1935
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Planning
Learning Outcome: 27.5. Analyze independent interventions nurses can implement for patients who are grieving.
MNL LO: Analyze the concept of grief and loss and its application to nursing care.

29) The nurse recognizes that the spouse of a terminally ill client has completed the grieving process, but the ill client is still alive. Which goal should the nurse identify for the ill client?
A) Prevent physical and spiritual distress of the spouse
B) Prevent despair in other family members
C) Prevent guilt in the client
D) Prevent isolation and loneliness for the client
Answer: D
Explanation: A) The client is less likely to feel physical and spiritual distress specifically related to the family member's detachment.
B) The client is less likely to feel despair specifically related to the family member's detachment.
C) The client is less likely to feel guilt specifically related to the family member's detachment.
D) If a family member completes the grieving process before the ill client dies, the family member may become detached, causing isolation and loneliness for the terminally ill client. Therefore, the nurse would need to implement interventions to prevent isolation and loneliness.
Page Ref: 1936
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Planning
Learning Outcome: 27.5. Analyze independent interventions nurses can implement for patients who are grieving.

MNL LO: Analyze the concept of grief and loss and its application to nursing care.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e **(Pearson)**

Module 28 Mood and Affect

The Concept of Mood and Affect

1) The nurse is caring for a client with a chronic health condition. Which condition should the nurse identify as a common complication associated with reduced role function?
A) Osteoporosis
B) Congestive heart failure
C) Diabetes
D) Depression
Answer: D
Explanation: A) There is not enough information to determine if the client will develop osteoporosis.
B) There is not enough information to determine if the client will develop congestive heart failure.
C) There is not enough information to determine if the client will develop diabetes.
D) Depression is one of the most common complications of chronic disease and can actually worsen the disease if it is not identified and treated.
Page Ref: 1953
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 28.1. Summarize the characteristics of normal mood and affect.
MNL LO: Analyze the concept of mood and affect and its application to nursing care.

2) A client with a 2-month-old child is experiencing insomnia, mood swings, and crying. Which interventions does the nurse anticipate being incorporated into a collaborative plan of care for the client experiencing postpartum depression? **Select all that apply.**
A) Electroconvulsive therapy
B) Psychosocial interventions
C) Antidepressants
D) Time management and exercise therapy
E) Cognitive-behavioral therapy
Answer: B, C
Explanation: A) Electroconvulsive therapy would be indicated for some cases of depression but not for postpartum depression.
B) The client is demonstrating signs of postpartum depression as evidenced by the mood swings, insomnia, and crying. Treatment for this disorder includes psychosocial interventions.
C) The client is demonstrating signs of postpartum depression as evidenced by the mood swings, insomnia, and crying. Treatment for this disorder includes antidepressants.
D) Time management and exercise therapy would not be beneficial for a client experiencing postpartum depression.
E) Cognitive-behavioral therapy would be indicated for some cases of depression but not for postpartum depression.
Page Ref: 1964, 1996
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 28.2. Differentiate alterations in mood and affect.
MNL LO: Analyze the concept of mood and affect and its application to nursing care.

3) The nurse is planning care for an adult client demonstrating symptoms of depression. Which assessment technique is most appropriate?
A) More time talking with the client
B) Ask family members about the client's demeanor
C) Beck Depression Inventory
D) Mood Disorder Questionnaire
Answer: C
Explanation: A) Because the client usually does not have the energy to talk, the nurse should not plan more time with the client to complete the assessment.
B) The nurse should not ask family members to talk about the client.
C) The Beck Depression Inventory is a series of 21 questions that the client answers in order to self-rate the level of depression. It takes approximately 10 minutes for the client to complete. The nurse can use it to help with the assessment of this client.
D) The Mood Disorder Questionnaire is used to screen adolescents for bipolar disorder, rather than general depression.
Page Ref: 1960
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 28.4. Explain the promotion of healthy mood and affect.
MNL LO: Analyze the concept of mood and affect and its application to nursing care.

4) A client is experiencing symptoms of depression. Which laboratory or diagnostic test would be the priority to determine if depression is being caused by another health problem?
A) Electrocardiogram
B) MRI of the brain
C) Thyroid function tests
D) Cerebral angiogram
Answer: C
Explanation: A) An electrocardiogram is not able to distinguish between mood disorders and physical disorders.
B) An MRI is not able to distinguish between mood disorders and physical disorders.
C) Thyroid function tests would be performed because thyroid disorders may mimic depression or hypomania.
D) A cerebral angiogram is not able to distinguish between mood disorders and physical disorders.
Page Ref: 1962
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 28.5. Differentiate common assessment procedures and rating scales used to assess mood and affect.
MNL LO: Analyze the concept of mood and affect and its application to nursing care.

5) A client is scheduled for electroconvulsive therapy (ECT) for the treatment of depression. Which instructions should the nurse include regarding this therapy? **Select all that apply.**

A) The procedure will take only 5 to 10 minutes.

B) These treatments will cure the depression.

C) Long-term memory loss often occurs after receiving ECT.

D) The treatments are known to help some, but not all, people with depression.

E) You will need to sign a consent form before having a treatment.

Answer: A, D, E

Explanation: A) The nurse should provide information to the client regarding ECT treatment for depression. The procedure takes only 5 to 10 minutes.

B) ECT will not cure depression.

C) Short-term memory loss is expected but long-term memory loss is not.

D) The treatment is known to help some people who experiencing depression, but not all.

E) A written informed consent form must be signed by the client before the procedure.

Page Ref: 1967

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 28.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in mood and affect.

MNL LO: Analyze the concept of mood and affect and its application to nursing care.

6) A client prescribed an antidepressant tells the nurse that the pill causes dizziness upon standing or changing position too quickly. This is a common side effect of which antidepressant medication?
A) Atypical antidepressant
B) Monoamine oxidase inhibitor (MAOI)
C) Selective serotonin reuptake inhibitor (SSRI)
D) Lithium
Answer: A
Explanation: A) One side effect of atypical antidepressants is orthostatic hypotension, so clients should be instructed to change positions slowly, especially when moving from a lying to a sitting position or a sitting to a standing position.
B) Orthostatic hypotension is not a common side effect of MAOIs.
C) Orthostatic hypotension is not a common side effect of SSRIs.
D) Lithium is used to treat bipolar disorder, not depression.
Page Ref: 1976
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 28.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in mood and affect.
MNL LO: Analyze the concept of mood and affect and its application to nursing care.

7) The nurse is caring for a client diagnosed with major depressive disorder (MDD). Upon assessment of the client, which clinical manifestations does the nurse recognize as consistent with this diagnosis?
A) Depressed mood or loss of interest occasionally for at least 1 week
B) Depressed mood sporadically for at least 2 years
C) Agitation, fatigue, suicidal ideation, feelings of guilt
D) Anxiety, change in appetite, grief, altered nutrition
Answer: C
Explanation: A) MDD is diagnosed when the client experiences either depressed mood or loss of interest most of the day, almost every day, for at least 2 weeks.
B) MDD is diagnosed when the client experiences either depressed mood or loss of interest most of the day, almost every day, for at least 2 weeks.
C) The depression must be accompanied by at least four symptoms, including sleep disturbance, significant weight change, fatigue, feelings of guilt or worthlessness, psychomotor agitation or retardation, poor concentration, and suicidal ideation or attempt.
D) Anxiety and grief are not symptoms of a major depressive disorder.
Page Ref: 1956
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 28.2. Differentiate alterations in mood and affect.
MNL LO: Analyze the concept of mood and affect and its application to nursing care.

8) The nurse educator is teaching a group of student nurses regarding depression, its pathophysiology, and the theories related to the disorder. Which statements will the instructor include about the theories of depression? **Select all that apply.**

A) Sociocultural theory emphasizes the role that social stressors play in the development of depression.

B) The sociocultural factor theory states that those who are depressed focus on negative messages in the environment and ignore positive experiences.

C) The learned helplessness theory states that individuals learn to be depressed in response to a self-perception of a lack of control over their life experiences.

D) The sociocultural factor theory suggests that all people have an inborn need for interpersonal relationships.

E) The learning theory states that individuals with depression typically experience little success in achieving gratification and little positive reinforcement in coping with negative incidents.

Answer: A, C, E

Explanation: A) Among the theories of depression, the sociocultural theory emphasizes the role that social stressors play in the development of depression.

B) The cognitive theory states that those who are depressed focus on negative messages in the environment and ignore positive experiences.

C) The learned helplessness theory states that individuals learn to be depressed in response to a self-perception of a lack of control over their life experiences.

D) The sociocultural theory does not suggest that all people have an inborn need for interpersonal relationships.

E) The learning theory states that individuals with depression typically experience little success in achieving gratification and little positive reinforcement in coping with negative incidents.

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Page Ref: 1971

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 28.2. Differentiate alterations in mood and affect.

MNL LO: Analyze the concept of mood and affect and its application to nursing care.

9) A client being treated for severe depression reports feeling better and having more energy. Which nursing action is a priority for this client at this time?

A) Promote safety
B) Encourage discussing feelings
C) Support low self-esteem
D) Identify family support

Answer: A

Explanation: A) The one risk that occurs with successful treatment of a client with depression is that once the depression begins to resolve, the underlying thought of suicide could prevail which impacts the client safety. With treatment, the client may begin to have more energy to make a plan regarding suicide.

B) The client reports feeling better. Encouraging the client to discuss feelings would not be the priority at this time.

C) The client reports feeling better. There is no evidence that the client is experiencing low self-esteem.

D) The client reports feeling better. There is no evidence that the client needs family support at this time.

Page Ref: 1962-1963

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 28.6. Analyze independent interventions nurses can implement for patients with alterations in mood and affect.

MNL LO: Analyze the concept of mood and affect and its application to nursing care.

10) A client with depression is receiving electroconvulsive therapy (ECT). Which interventions should the nurse plan when caring for this client? **Select all that apply.**

A) Provide a muscle relaxant as prescribed
B) Ensure an open airway during the procedure
C) Monitor heart and brain activity during the procedure
D) Assess oxygen saturation via pulse oximetry
E) Prepare for discharge after the procedure

Answer: A, B, C, D

Explanation: A) A client having an ECT treatment will be provided with a muscle relaxant prior to the procedure as prescribed.
B) The airway needs to be monitored during the procedure.
C) During the procedure the electrocardiogram and brain wave activity is monitored.
D) Oxygen saturation level is to be monitored with a pulse oximeter during the procedure.
E) The client will not be discharged immediately after the treatment. Vital signs will be monitored for several hours afterward and the client will experience mild confusion or amnesia.

Page Ref: 1967

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 28.7. Summarize collaborative therapies used by interprofessional teams for patients with alterations in mood and affect.

MNL LO: Analyze the concept of mood and affect and its application to nursing care.

11) The nurse observes a client being treated for depression sitting with the head down and avoiding conversation with peers. Which nursing intervention is most appropriate for this client?
A) Ask open-ended questions about the client's feelings.
B) Ask the client closed-ended questions.
C) Encourage a peer to sit with the client and the nurse.
D) Tell the client that lack of involvement leads to more depression.
Answer: A
Explanation: A) An open-ended question encourages more than a one-word response.
B) A closed-ended question is unlikely to encourage continued communication.
C) Depressed clients should be comfortable with a one-to-one interaction prior to other client involvement.
D) Telling the client that lack of involvement and participation will cause more depression is not encouraging communication.
Page Ref: 1961
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 28.5. Differentiate common assessment procedures and rating scales used to assess mood and affect.
MNL LO: Analyze the concept of mood and affect and its application to nursing care.

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12) Which condition is associated with the highest rate of comorbidity with depression?
A) Alcohol abuse
B) Obesity
C) Back problems
D) Hypertension
Answer: A
Explanation: A) The rate of comorbidity between mood disorders and substance abuse disorders is high. Depressive disorders are the most common psychiatric disorders among people with alcohol use disorder. Furthermore, individuals with alcohol dependence are 3.7 times more likely to also have major depressive disorder. Individuals with bipolar disorder have high rates of alcohol and substance abuse, and suicide is the leading cause of death among individuals with substance abuse disorders. Obesity, back problems, and hypertension do not share this same link with mood disorders.
B) Obesity does not share this same link with mood disorders.
C) Back problems do not share this same link with mood disorders.
D) Hypertension does not share this same link with mood disorders.
Page Ref: 1958
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 28.3. Outline the relationship between mood and affect and other concepts.
MNL LO: Analyze the concept of mood and affect and its application to nursing care.

13) Which intervention is a primary prevention strategy for depression?
A) Regular screening for depression
B) Providing education about stress management
C) Counseling clients about their risk for mood disorders
D) Developing community-based mental health programs
Answer: B
Explanation: A) Regular screening for depression is a secondary prevention method.
B) Providing education about stress management is a primary prevention method for depression.
C) Counseling clients about their risk for mood disorders is a secondary prevention method.
D) Developing community-based mental health programs is a tertiary prevention method.
Page Ref: 1959-1960
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies:.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 28.4. Explain the promotion of healthy mood and affect.
MNL LO: Analyze the concept of mood and affect and its application to nursing care.

14) The nurse at a psychiatrist's office is reviewing the medication prescribed to several new clients for mood disorders. Which order would the nurse question?
A) A prescription for paroxetine for a 15-year-old boy with depression
B) A prescription for fluoxetine for a 14-year-old girl with depression
C) A prescription for sertraline for a 10-year-old boy with obsessive-compulsive disorder
D) A prescription for sertraline for an 11-year-old girl with depression
Answer: A
Explanation: A) The FDA does not recommend paroxetine to treat depression in children and adolescents because of an increased risk in suicidal thinking and behavior during initial treatment.
B) Fluoxetine would be appropriate for the client's age and disorder.
C) Sertraline would be appropriate for the client's age and disorder.
D) Sertraline would be appropriate for the client's age and disorder.
Page Ref: 1969
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 28.8. Differentiate considerations related to the assessment and care of patients with alterations in mood and affect throughout the lifespan.
MNL LO: Analyze the concept of mood and affect and its application to nursing care.

Exemplar 28.A Depression

1) A client who was widowed 3 years ago states, "I don't have many friends. The only people I visit with are some acquaintances at the local bar." Which health problem does the nurse realize the client is at risk for based on this statement?
A) Bipolar disorder
B) Depression
C) Suicide
D) Extended grief
Answer: B
Explanation: A) Bipolar disorder is characterized by periods of mania with periods of depression. The client is not describing or demonstrating these periods.
B) Risk factors for the development of depression include family history of depression or other mental illness, female gender, history of child abuse or trauma, unemployment, poverty, lower education, lack of social supports, and bullying. The client is most at risk for developing depression.
C) The client's statement does not indicate a risk for suicide at this time.
D) Whether the client is still grieving is not evident from this statement.
Page Ref: 1972
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 28.A. Analyze depressive disorders and relevant nursing care. Describe the etiology of depressive disorders.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with depression.

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2) A client receiving pain medication for abdominal discomfort reports no relief of pain and continues to describe multiple somatic complaints. The client also describes feelings of discouragement and hopelessness related to the pain, because the healthcare team has not yet found a cause for the pain. Which action by the nurse is appropriate?

A) Assessing the client for depression
B) Obtaining an order for different pain medication
C) Contacting the family to talk to the client
D) Reviewing of the client's laboratory values

Answer: A

Explanation: A) Symptoms of depression may include multiple somatic complaints and reports of persistent chronic pain and some vague pain. Feelings of discouragement and hopelessness are also symptoms of depression. Therefore, further assessment for depression is warranted.
B) Obtaining different pain medication would not treat potential psychologic problems.
C) The family may also be ineffective in determining the client's psychologic need.
D) Reviewing the laboratory values is not indicated in this case.

Page Ref: 1972
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 28.A. Analyze depressive disorders and relevant nursing care. Identify the clinical manifestations of depressive disorders.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with depression.

3) The nurse is caring for a client who displays symptoms associated with seasonal affective disorder (SAD). Which treatment would the nurse question as inappropriate for this client?
A) Cognitive-behavioral therapy
B) Light therapy
C) Bupropion extended-release
D) Selective serotonin reuptake inhibitor (SSRI)
Answer: D
Explanation: A) Cognitive-behavioral therapy is appropriate for a client with SAD.
B) Light therapy is appropriate for a client with SAD.
C) Bupropion extended release medication is appropriate for a client with SAD.
D) The nurse would question the order for an SSRI. This medication is used in the treatment of major depressive disorder (MDD) and dysthymic disorder, not SAD.
Page Ref: 1973
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 28.A. Analyze depressive disorders and relevant nursing care. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with a depressive disorder.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with depression.

4) The nurse working is completing a suicide assessment with a client diagnosed with major depressive disorder (MDD). Which actions by the nurse are appropriate when conducting a suicide assessment? **Select all that apply.**
A) Use indirect questioning.
B) Ask if the client has any thought of suicide.
C) Avoid asking about suicide to avoid "planting the idea" in the client's mind.
D) Assess the lethality of the suicide plan if one exists.
E) If the client has suicidal thoughts, assess whether or not the client would act on them.
Answer: B, D, E
Explanation: A) When performing a suicide assessment, the nurse should always use direct, not indirect, questioning.
B) The nurse should ask if the client has any thought of suicide.
C) Asking about suicide will not "plant the idea" in the client's mind.
D) The nurse should assess the lethality of the suicide plan if one exists.
E) The nurse should ask if the client will act on these thoughts of suicide if a plan exists.
Page Ref: 1979
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: IX.7. Provide appropriate patient teaching that reflects developmental state, age, culture; 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 28.A. Analyze depressive disorders and relevant nursing care. Apply the nursing process in providing culturally competent care to an individual with a depressive disorder.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with depression.

5) A client tells the nurse about rarely going outdoors in the winter because of a lack of energy or desire. Based on this data, which does the nurse suspect the client is experiencing?
A) Seasonal affective disorder
B) Side effect of medication
C) Situational depression
D) Anxiety
Answer: A
Explanation: A) A decreased exposure to sunlight will reduce the production of serotonin in the brain, and that can cause a type of depression termed seasonal affective disorder.
B) The nurse does not have enough information to determine if the client is experiencing a side effect of medication.
C) Situational depression is a depressive episode that occurs after an identifiable life event.
D) The nurse does not have enough information to determine if the client is experiencing anxiety.
Page Ref: 1973-1974
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 28.A. Analyze depressive disorders and relevant nursing care. Identify the clinical manifestations of depressive disorders.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with depression.

6) During a home visit, the partner of a client states that the house is a mess and does not want to have any friends or family visit because the client does nothing to help. Which situation should the nurse suspect is occurring when the client begins to cry?

A) Evidence of low blood glucose levels
B) Financial struggles within the family
C) Possible situational depression
D) Spousal abuse

Answer: C

Explanation: A) The nurse cannot determine that the situation is due to low blood glucose levels.
B) The nurse cannot determine if the family is having financial struggles.
C) Manifestations associated with situational depression include anhedonia, psychomotor retardation feelings of sadness, hopelessness, powerlessness, apathy, or guilt.
D) There is no evidence of spousal abuse at this time.

Page Ref: 1954, 1975
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 28.A. Analyze depressive disorders and relevant nursing care. Identify the clinical manifestations of depressive disorders.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with depression.

7) The nurse is providing care for a client who is experiencing situational depression after the death of a parent. During the assessment, the nurse learns that the client has returned to work, is caring for family, and spends quiet time reflecting on life and the future. Which conclusion by the nurse is most appropriate?
A) The client is working through the grief process.
B) The client is experiencing denial regarding the death of a parent.
C) The client is exhibiting ineffective coping.
D) The client is experiencing anxiety.
Answer: A
Explanation: A) The client has returned to work, cares for family, and reflects on life and future. Clients who are working through the grief process tend to participate in activities as they begin to heal.
B) The client is not denying the death of the parent.
C) The client is not demonstrating ineffective coping.
D) The client is not demonstrating anxiety.
Page Ref: 1975
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 28.A. Analyze depressive disorders and relevant nursing care. Identify the clinical manifestations of depressive disorders.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with depression.

8) Which molecule has been implicated in the pathophysiology of depression?
A) Brain natriuretic peptide
B) Dopamine
C) Epinephrine
D) Calcitonin
Answer: B
Explanation: A) Brain natriuretic peptide is not implicated in the pathophysiology of depression.
B) Several different neurotransmitters have been implicated in the pathophysiology of depression, including serotonin, norepinephrine, dopamine, acetylcholine, gamma-aminobutyric acid, and glutamate.
C) Epinephrine is not implicated in the pathophysiology of depression.
D) Calcitonin is not implicated in the pathophysiology of depression.
Page Ref: 1971
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 28.A. Analyze depressive disorders and relevant nursing care. Describe the pathophysiology of depressive disorders.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with depression.

9) Which individual has the most risk factors for depression?

A) A 43-year-old man who was fired from his job 8 months ago and has been unable to find employment

B) A 38-year-old woman who recently moved away from all her family to go to graduate school

C) A 68-year-old man who lost his wife in a car accident and lives close to two of their three children

D) A 19-year-old woman who was emotionally and physically abused as a child and dropped out of school at the age of 16 when she became pregnant

Answer: D

Explanation: A) The potential for poverty is the only risk factor the 43-year-old client has for depression.

B) The 38-year-old woman has one risk factor for depression — a lack of social support because of relocating to attend school.

C) The 68-year-old male client did have a traumatic experience; however, he does have social support. The risk for depression is still low.

D) The 19-year-old woman has three risk factors for depression (female gender, history of child abuse, lower education).

Page Ref: 1972

Cognitive Level: Understanding

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 28.A. Analyze depressive disorders and relevant nursing care. Compare the risk factors and prevention of depressive disorders.

MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with depression.

10) The nurse is performing an assessment on an 8-year-old child whose mother is concerned has depression. Which symptoms of depression are consistent with a child of this age?
A) Regression in toilet training
B) Self-destructive play themes
C) Decrease in academic performance
D) Poor self-care
Answer: C
Explanation: A) Regression in toilet training is more common for toddlers with depression.
B) Preschoolers may demonstrate symptoms of depression by using self-destructive play themes.
C) An 8-year-old child may show a decrease in academic performance, change in physical activity, somatic complaints, and loss of friends.
D) Adolescents who are depressed may have poor self-care.
Page Ref: 1978
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 28.A. Analyze depressive disorders and relevant nursing care. Differentiate care of patients with depressive disorders across the lifespan.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with depression.

11) The nurse is teaching to an older adult who was prescribed escitalopram for depression. The client is also taking medication for type 2 diabetes, hypertension, and heart disease. Which information should the nurse include in her teaching?
A) The need to come in for more frequent monitoring
B) Potential for memory problems
C) The need to stop driving
D) Reduced need to take medication for hypertension
Answer: A
Explanation: A) Polypharmacy issues make prescribing for older adults a challenge, and older adults taking psychotropic medications such as escitalopram often require more frequent monitoring and laboratory tests.
B) Memory problems are a symptom of depression in older adults, so any memory problems associated with depression should decrease, not increase, with treatment.
C) Not being able to drive is often a precipitating factor for depression.
D) The client will still need to take other prescribed medications.
Page Ref: 1978
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 28.A. Analyze depressive disorders and relevant nursing care. Differentiate care of patients with depressive disorders across the lifespan.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with depression.

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Exemplar 28.B Bipolar Disorders

1) The family of a client with a bipolar disorder asks the nurse what the diagnosis means. Which response by the nurse is appropriate?

A) "Bipolar disorder is a type of depression that includes attention deficit disorder symptoms."

B) "Bipolar disorder means there are cycles of mania, hypomania and depressive episodes. "

C) "Bipolar disorder just means that the mood alternates with the seasons, and it becomes worse in the winter."

D) "Bipolar disorder is just another type of depression, except depression occurs in cycles."

Answer: B

Explanation: A) Bipolar disorder does not include attention deficit disorder.

B) Bipolar disorder is characterized by mania, hypomania, and depressive episodes.

C) A mood change that becomes worse in the winter is called seasonal affective disorder.

D) Bipolar disorder is not another type of depression that occurs in cycles.

Page Ref: 1982

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 28.B. Analyze bipolar disorders and relevant nursing care. Identify the clinical manifestations of bipolar disorders.

MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with bipolar disorder.

2) The nurse is providing care to a client who is exhibiting manifestations of a mood disorder. Which assessment findings indicate that the client may be at an increased risk for bipolar disorder? **Select all that apply.**

A) Blood pressure 120/80 mmHg
B) History of childhood neglect
C) Works out at the gym every week
D) Currently employed
E) Mother diagnosed with bipolar disorder

Answer: B, E

Explanation: A) A blood pressure of 120/80 mmHg does not put a client at risk for bipolar disorders.

B) Risk factors for bipolar disorder include a history of adverse childhood experiences such as neglect.

C) Working out regularly is not a risk factor for bipolar disorders.

D) Being employed is not a risk factor for bipolar disorders.

E) Risk factors for bipolar disorder include a family history of bipolar disorders.

Page Ref: 1982

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 28.B. Analyze bipolar disorders and relevant nursing care. Compare the risk factors and prevention of bipolar disorders.

MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with bipolar disorder.

3) A client with bipolar disorder expresses the desire to harm self. For which problem should the nurse plan care for this client?
A) Poor impulse control
B) Inadequate social skills
C) Risk of suicide
D) Elevated mood
Answer: C
Explanation: A) The client is not demonstrating evidence of poor impulse control.
B) The client is not demonstrating inadequate social skills.
C) The priority for a client with bipolar disorder and suicidal ideas is safety. The priority problem for care is the risk for suicide.
D) The client is not demonstrating an elevated mood.
Page Ref: 1989
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 28.B. Analyze bipolar disorders and relevant nursing care. Apply the nursing process in providing culturally competent care to an individual with bipolar disorder.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with bipolar disorder.

4) A client in the manic phase of bipolar disorder is unable to sleep during the night. Which interventions could be helpful to this client? **Select all that apply.**
A) Engage in conversation.
B) Extend daytime naps.
C) Encourage the client to watch television.
D) Assist the client with a warm bath and provide a light snack.
E) Encourage the client to listen to soothing music.
Answer: D, E
Explanation: A) Long conversations should be avoided.
B) To promote nighttime sleeping, daytime naps should be limited and not extended.
C) Stimulation such as watching television should be avoided.
D) To promote sleep during the night, the nurse should encourage pre-sleep routines, like a warm bath, and provide a snack.
E) Listening to soothing music also helps to promote sleep.
Page Ref: 1990
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity
Standards: QSEN Competencies: III.A.2 Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 28.B. Analyze bipolar disorders and relevant nursing care. Apply the nursing process in providing culturally competent care to an individual with bipolar disorder.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with bipolar disorder.

5) Which client observation indicates that interventions provided to a client in the manic phase of bipolar disorder have improved self-care activities?

A) Completed morning bath and changed clothes

B) Washes hands after using the toilet when reminded

C) Cleaned liquid spilled on floor but did not change clothes

D) Brushes own teeth every time when reminded

Answer: A

Explanation: A) The client completing a morning bath and changing clothes are evidence that the interventions succeeded in improving the client's self-care activities.

B) The client needing to be reminded to wash hands after toileting would not be a successful outcome.

C) The client cleaning spilled liquid on the floor but not changing clothes is not evidence of improvement in self-care activities.

D) The client needing to be reminded to brush teeth would not be a successful outcome.

Page Ref: 1991

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 28.B. Analyze bipolar disorders and relevant nursing care. Apply the nursing process in providing culturally competent care to an individual with bipolar disorder.

MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with bipolar disorder.

6) A client in the manic phase of bipolar disorder is prescribed lithium and has a current lithium blood level of 0.4 mEq/L. Which clinical manifestation does the nurse anticipate when assessing this client?
A) A decrease in manic behavior
B) Hyperactivity and pressured speech
C) A return to baseline behavior, calm and rational
D) Signs and symptoms of depression
Answer: B
Explanation: A) The client will not display a decrease in manic behaviors.
B) A therapeutic lithium level is 0.6-1.2 mEq/L. Because this client's level is low, behaviors will indicate mania, that is, hyperactivity and pressured speech, because the client is in a manic phase.
C) The client will not display a return to baseline behavior.
D) The low lithium levels will not prevent the client from cycling to a depressive phase, but currently the client is in a manic phase, not a depressive phase, so the client will not display signs and symptoms of depression.
Page Ref: 1985
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 28.B. Analyze bipolar disorders and relevant nursing care. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with bipolar disorder.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with bipolar disorder.

7) A client in the manic phase of bipolar disorder will not sit down to eat. Which actions should the nurse take to ensure adequate nutrition and improved self-care of this client? **Select all that apply.**

A) Provide a sedative before meals.
B) Discuss finger-food options with the dietitian.
C) Use a jacket restraint at mealtimes.
D) Ask the healthcare provider if intravenous feedings would be applicable.
E) Provide nutritious liquids.

Answer: B, E

Explanation: A) Sedation is not an appropriate intervention and should not be done.
B) The client who is unable to sit down and eat is most likely to consume frequent small snacks that can be eaten "on the go." The nurse should discuss with a dietitian to ensure that high-calorie finger foods are available on the nursing unit until the client is able to attend regular meals.
C) Restraining is not appropriate intervention and should not be done.
D) Intravenous therapy is not an appropriate intervention and should not be done.
E) The nurse should ensure that nutritious liquids are available on the nursing unit until the client is able to attend regular meals.

Page Ref: 1990
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 28.B. Analyze bipolar disorders and relevant nursing care. Apply the nursing process in providing culturally competent care to an individual with bipolar disorder.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with bipolar disorder.

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8) A student nurse researches bipolar disorder in preparation to assist with the care of a client with the disorder. Which statements are true regarding the pathophysiology and etiology of bipolar disorder? **Select all that apply.**

A) No definitive cause or specific pathophysiology has been identified for bipolar spectrum disorders.

B) Bipolar disorders, schizophrenia, and major depressive disorders share biological susceptibility and inheritance patterns.

C) Immunologic abnormalities may contribute to the pathophysiology of mania and bipolar disorder.

D) Children of parents with bipolar disorder have an increased risk of developing the disorder.

E) Stressful life events and an emotionally overinvolved, hostile, and critical communication pattern are factors associated with heritability of the disorder.

Answer: A, B, D, E

Explanation: A) There are no definitive causes or specific pathophysiology identified for bipolar spectrum disorders.

B) Bipolar disorders, schizophrenia, and major depressive disorders share biological susceptibility and inheritance patterns.

C) Immunologic abnormalities are not identified as contributing to mania and bipolar disorder.

D) Children of parents with bipolar disorders are at increased risk of having the disorder.

E) Stressful life events and emotionally overinvolved, hostile, and critical communication patterns are factors associated with inheriting the disorder.

Page Ref: 1982

Cognitive Level: Understanding

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 28.B. Analyze bipolar disorders and relevant nursing care. Describe the pathophysiology of bipolar disorders.

MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with bipolar disorder.

9) The nurse understands that bipolar disorders affect clients differently across the lifespan. Which information is true regarding bipolar disorder and lifespan considerations?
A) Children with bipolar disorders present with mood changes only.
B) Children with bipolar disorders rarely exhibit violent tempers.
C) Suicide risk does not increase in adolescents and teenagers who are diagnosed with bipolar disorders.
D) Mood changes in adolescents may be mistaken for bipolar disorder
Answer: D
Explanation: A) Children with bipolar disorders present with mood and behavioral changes.
B) Children with bipolar disorders can exhibit violent temper tantrums.
C) Suicide risk is increased among all age groups with bipolar disorders.
D) Because teenagers commonly show mood changes, including changes in sleeping and eating patterns, it is important not to mistake typical mood swings for bipolar disorder.
Page Ref: 1988
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 28.B. Analyze bipolar disorders and relevant nursing care. Differentiate care of patients with bipolar disorder across the lifespan.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with bipolar disorder.

10) Which statement about bipolar disorder is true?
A) Bipolar disorder can be prevented.
B) Bipolar disorder does not affect older adults.
C) Symptoms of hypomania do not require hospitalization.
D) Bipolar disorders typically appear between the ages of 25 and 50.
Answer: C
Explanation: A) There is no prevention for bipolar disorders.
B) Bipolar disorder can develop in older adults.
C) The behaviors in hypomania are not severe enough to require hospitalization and do not have any psychotic symptoms.
D) Bipolar disorders can develop in childhood.
Page Ref: 1943
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 28.B. Analyze bipolar disorders and relevant nursing care. Describe the etiology of bipolar disorders.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with bipolar disorder.

11) A client with bipolar disorder taking lithium learns of being pregnant and is concerned about the effects of the medication on the developing fetus. Which potential fetal effect should the nurse explain to the client?

A) Craniofacial defects

B) Neural tube defects

C) Heart defects

D) Gastrointestinal defects

Answer: C

Explanation: A) Craniofacial defects are more common with divalproex.

B) Neural tube defects are more common with divalproex.

C) The risk for development of heart defects increases with lithium use during the first trimester, so the client will need counseling related to assessments for potential heart defects.

D) Gastrointestinal defects are not commonly associated with medications for bipolar disorder.

Page Ref: 1988

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 28.B. Analyze bipolar disorders and relevant nursing care. Differentiate care of patients with bipolar disorder across the lifespan.

MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with bipolar disorder.

Exemplar 28.C Postpartum Depression

1) A postpartum client cannot understand why she does not enjoy being with the baby. Based on this data, which condition should the nurse suspect the client is experiencing?
A) Postpartum infection
B) Postpartum depression
C) Postpartum psychosis
D) Postpartum blues
Answer: B
Explanation: A) Postpartum infection has nothing to do with this situation.
B) Postpartum depression is characterized by feelings of failure and self-accusation, among others.
C) Postpartum psychosis is more severe, and includes hallucinations and irrationality, which are not represented in this situation.
D) Postpartum blues is characterized by mild depression interspersed with happier feelings and is self-limiting.
Page Ref: 1993
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 28.C. Analyze postpartum depression and relevant nursing care. Identify the clinical manifestations of postpartum depression and psychosis.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with postpartum depression.

2) A client who is 4 weeks postpartum reports having no appetite and wants to sleep all day. Which conclusion should the nurse make from this information?
A) The client is feeling blue, which is normal.
B) The client's sleep-wake cycle is disrupted.
C) The client may be experiencing postpartum depression.
D) The client is developing postpartum psychosis.
Answer: C
Explanation: A) The client could be developing postpartum depression and not just "the blues."
B) The nurse has no way of knowing what the client's sleep-wake cycle is.
C) Lack of appetite and the desire to sleep are symptoms of developing postpartum depression.
D) The client would need to have more acute symptoms such as hearing voices to consider postpartum psychosis.
Page Ref: 1993
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 28.C. Analyze postpartum depression and relevant nursing care. Identify the clinical manifestations of postpartum depression and psychosis.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with postpartum depression.

3) The nurse caring for a postpartum client would consider the problem of inadequate coping skills when the client demonstrates which behavior?
A) Reading material on care of a newborn
B) Lying in bed, lights dim, and refusing to spend time with the baby
C) Cuddling the new infant
D) Talking with friends and family on the phone
Answer: B
Explanation: A) Reading material on newborn care indicates effective coping.
B) The postpartum client who is lying in bed in a darkened room and not wanting to spend time with the new baby is demonstrating signs of inadequate coping skills.
C) Cuddling the new infant indicates effective coping.
D) Talking with friends and family on the phone indicates effective coping.
Page Ref: 1998
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 28.C. Analyze postpartum depression and relevant nursing care. Apply the nursing process in providing culturally competent care to an individual with postpartum depression.

MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with postpartum depression.

4) The nurse is planning care for a client with a history of postpartum depression after the births of all her children. Based on this data, which will the nurse include in the client's plan of care? **Select all that apply.**
A) Encouraging the client to take advantage of those who want to help and maintain outside interests
B) Contacting the healthcare provider to ensure the client is prescribed medication for postpartum depression
C) Ensuring the client is getting adequate sleep
D) Focusing on the care the other children need
E) Engage in light exercises 3 to 5 times a week
Answer: A, C, E
Explanation: A) Because the client has a history of postpartum depression with other children, the nurse needs to plan prevention strategies for the client. By taking advantage of those who want to help and maintaining outside interests, the client may prevent the onset of postpartum depression.
B) Medication for postpartum depression will not help prevent the condition from developing.
C) Getting adequate sleep is a strategy to prevent postpartum depression.
D) Focusing on other children's needs will not prevent the condition from developing.
E) Light exercise 3 to 5 times a week is an action to help prevent the development of postpartum depression.
Page Ref: 1995
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 28.C. Analyze postpartum depression and relevant nursing care. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with postpartum depression.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with postpartum depression.

5) Which data should suggest to the nurse that a client experiencing postpartum depression is improving?
A) Client wearing clean clothes, holding baby while rocking in a chair
B) Spouse making dinner, client in bed asleep, baby in rocker in the kitchen
C) Dirty dishes in the sink, beds unmade, and client wearing clothing for sleep
D) Client watching television in the living room while the baby is in the crib crying
Answer: A
Explanation: A) The nurse who observes the client wearing clean clothes, holding the baby while rocking in a chair, should determine that treatment for postpartum depression has been effective because these are signs the client is improving.
B) The client who is sleeping while the spouse is making dinner and watching the baby would indicate treatment has not been effective at all.
C) Having an unkept home and the client wearing clothing for sleep indicates interventions have not been effective.
D) The client watching television while the baby is crying in the crib indicates that interventions have not been effective.
Page Ref: 1999
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 28.C. Analyze postpartum depression and relevant nursing care. Identify the clinical manifestations of postpartum depression and psychosis.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with postpartum depression.

6) A client who is breastfeeding has been diagnosed with postpartum depression after delivering a first child. Which treatment should the nurse anticipate being prescribed for this client? **Select all that apply.**
A) Hospitalization
B) Antidepressants
C) The drug doxepin
D) The drug nefazodone
E) Psychosocial support
Answer: B, E
Explanation: A) Hospitalization is not typically prescribed to treat postpartum depression.
B) Antidepressants are recommended to treat postpartum depression regardless of breastfeeding.
C) Doxepin is not recommended to treat postpartum depression.
D) Nefazodone is not recommended to treat postpartum depression.
E) Psychosocial support is recommended to treat postpartum depression.
Page Ref: 1996
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 28.C. Analyze postpartum depression and relevant nursing care. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with postpartum depression.

MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with postpartum depression.

7) The nurse is instructing a new mother on the strategies to prevent the development of postpartum depression. Which instructions will the nurse include in the teaching session with the client? **Select all that apply.**
A) Restrict fluids and eat a low-fat diet to help to avoid the onset of postpartum depression.
B) Realize that feeling depressed after delivering a baby is normal and can last for months.
C) The only way to avoid postpartum depression is to not have children.
D) Encourage the client to plan how to manage the baby's care needs at home to help adjust to motherhood.
E) Instruct the client to recognize the signs and symptoms of postpartum depression and contact the healthcare provider if these occur.
Answer: D, E
Explanation: A) Restricting fluids and eating a low-fat diet will not prevent postpartum depression and could harm the new mother's physiologic status.
B) It is not normal to feel depressed for months after delivering a baby.
C) Not having children is not the only way to avoid postpartum depression.
D) The nurse should encourage the client to plan how to manage the baby's care needs at home to help adjust to motherhood.
E) The nurse should instruct the client on the signs and symptoms of postpartum depression with the direction to contact the healthcare provider if this occurs.
Page Ref: 1995
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 28.C. Analyze postpartum depression and relevant nursing care. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with postpartum depression.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with postpartum depression.

8) The nurse is assessing a client's risk for developing postpartum depression. Which risk factor should the nurse identify for this condition?
A) Multiparity (multiple pregnancies)
B) Overwhelming family support
C) History of a mood disorder
D) Supportive relationship with spouse
Answer: C
Explanation: A) Parity is not a risk factor for postpartum depression.
B) Lack of family support is a risk factor for the development of postpartum depression.
C) A history of a mood disorder is a risk factor for the development of postpartum depression.
D) Lack of spousal support is a risk factor for the development of postpartum depression.
Page Ref: 1994
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 28.C. Analyze postpartum depression and relevant nursing care. Identify the clinical manifestations of postpartum depression and psychosis.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with postpartum depression.

9) Which potential problem is the greatest risk for a client diagnosed with postpartum psychosis?
A) Infanticide
B) Hallucinations
C) Insomnia
D) Poor judgment
Answer: A
Explanation: A) The greatest risk for a client with postpartum psychosis is infanticide.
B) The client with psychosis may experience delusions or hallucinations that support the perceptions that the infant should not be allowed to live.
C) Insomnia is not the greatest problem for a client with postpartum psychosis.
D) Poor judgment is not the greatest problem for a client with postpartum psychosis.
Page Ref: 1995
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 28.C. Analyze postpartum depression and relevant nursing care. Identify the clinical manifestations of postpartum depression and psychosis.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with postpartum depression.

10) Which nursing intervention would the nurse anticipate to meet the needs of the family of a client experiencing postpartum depression?

A) Emotional support for the newborn
B) Emotional support for the partner
C) Temporary placement of the newborn in foster care
D) Childcare for the newborn

Answer: B

Explanation: A) Although newborns need security and safety, nursing interventions of emotional support are not age appropriate.

B) The partner may have a difficult time adjusting to both a newborn and the client's postpartum depression. The partner may feel hurt or worried about the client and overwhelmed by additional responsibilities.

C) The child should not be placed in foster care unless the client threatens harm to the newborn and no one else is available to care for the child.

D) The nurse is not responsible for providing childcare for the newborn.

Page Ref: 1998-1999

Cognitive Level: Understanding

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

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Learning Outcome: 28.C. Analyze postpartum depression and relevant nursing care. Apply the nursing process in providing culturally competent care to an individual with postpartum depression.

MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient with postpartum depression.

Exemplar 28.D Suicide

1) A client says family members would be better off if the client were dead. In which way should the nurse categorize the client's statement?
A) A suicide attempt
B) Suicide planning
C) A suicide threat
D) Suicidal ideation
Answer: D
Explanation: A) A suicide attempt is a nonfatal, self-inflicted, destructive act with explicit or inferred intent to die.
B) A suicide plan is a decision to commit suicide and an identified method.
C) A suicide threat is more serious than a casual statement of suicidal intent and is accompanied by other behavior changes.
D) Suicidal ideation is having thoughts of harming or killing oneself.
Page Ref: 2000
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment
Learning Outcome: 28.D. Analyze the nurse's role in preventing and responding to patient suicide attempts. Identify the clinical manifestations of suicidal ideation.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient at risk for suicide.

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2) Which assessment findings indicate to the nurse that a client is at increased risk for suicide? **Select all that apply.**
A) Substance abuse
B) Age 59
C) Plays golf twice a week
D) Widowed for 6 months
E) Recently started a new job
Answer: A, D
Explanation: A) Substance abuse is a risk factor for suicide.
B) Suicide is the fourth leading cause of death for those age 35 to 54.
C) Engagement in activities does not increase the risk for suicidal ideation or behavior.
D) A recent loss of a significant relationship is a risk factor for suicide.
E) Active employment does not increase the risk for suicidal ideation or behavior.
Page Ref: 2002
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment
Learning Outcome: 28.D. Analyze the nurse's role in preventing and responding to patient suicide attempts. Compare risk and protective factors for suicide.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient at risk for suicide.

3) An adolescent client hospitalized with asphyxiation following a suicide attempt says, "I know other kids have the same problems I do, but I just wanted to make it stop." Which action by the nurse is the most appropriate?
A) Discuss the client's attendance at school and what activities are enjoyed.
B) Suggest the client listen to music and read a light novel to reduce stress.
C) Ask if the client would like to talk about stressors and problems.
D) Ask what is so devastating that the client needed to commit suicide.
Answer: C
Explanation: A) The nurse should not try to distract the client by asking about school and activities.
B) Suggesting the client read and listen to music may not be sufficient to reduce the client's stress.
C) Those who attempt suicide are overcome by, and overwhelmed with, stressors in their lives. The nurse should ask the client to talk about stressors and problems.
D) The nurse should not ask the client about what caused the attempt at suicide.
Page Ref: 2008
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Implementation
Learning Outcome: 28.D. Analyze the nurse's role in preventing and responding to patient suicide attempts. Apply the nursing process in providing culturally competent care to an individual at risk for suicide.

MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient at risk for suicide.

4) The nurse is caring for a client recovering from a suicide attempt. Which client statement indicates to the nurse that the risk of suicide has diminished?
A) "I am not looking forward to going home with my parents."
B) "I now know that threatening suicide will help me get what I want from my parents."
C) "Even though I failed this time, I lived to think about it again."
D) "I am looking forward to going to school and seeing my friends."
Answer: D
Explanation: A) Not looking forward to going home indicates the client may need further intervention either before discharge or once at home.
B) The statement about threatening suicide to manipulate parents indicates the client may need further intervention either before discharge or once at home.
C) The statement about thinking about attempting suicide again indicates the client may need further intervention either before discharge or once at home.
D) The statement "I am looking forward to going to school and seeing my friends" indicates a desire to live, which is a desired outcome of care for a client who is at risk for suicide.
Page Ref: 2009
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Evaluation
Learning Outcome: 28.D. Analyze the nurse's role in preventing and responding to patient suicide attempts. Apply the nursing process in providing culturally competent care to an individual at risk for suicide.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient at risk for suicide.

5) A client who has attempted suicide in the past reports feeling better since being prescribed medication. Which conclusion should the nurse make from this information?
A) Improved mood
B) Improved sleep
C) Improved feelings of guilt
D) Improved appetite
Answer: A
Explanation: A) Antidepressants, mood stabilizers, and antipsychotics are used to treat symptoms that contribute to suicide ideation.
B) Medication to treat a client who has attempted suicide is not prescribed to improve sleep.
C) Medications to treat a client who has attempted suicide is not prescribed to improve feelings of guilt.
D) Medications to treat a client who has attempted suicide is not prescribed to improve appetite.
Page Ref: 2004-2005
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Evaluation
Learning Outcome: 28.D. Analyze the nurse's role in preventing and responding to patient suicide attempts. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual at risk for suicide.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient at risk for suicide.

6) The nurse is assessing a client being treated for thoughts of suicide. Which assessment findings would indicate that the client is at a high level risk of suicide? **Select all that apply.**
A) Displays mild depression.
B) Shows curiosity about death.
C) Has access to a gun at home.
D) Admits planning to end life.
E) Discusses a detailed plan to end life.
Answer: C, D, E
Explanation: A) Displaying mild depression indicates low-level risk for suicide.
B) Showing curiosity about death indicates low-level risk for suicide.
C) A client who has access to a gun at home is at high risk for suicide.
D) A client who admits planning to end life is at high risk for suicide.
E) A client who discusses a plan to end life in detail is at high risk for suicide.
Page Ref: 2002
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment
Learning Outcome: 28.D. Analyze the nurse's role in preventing and responding to patient suicide attempts. Identify the clinical manifestations of suicidal ideation.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient at risk for suicide.

7) The nurse is interviewing a client who recently attempted suicide. Which question is appropriate for the nurse to ask the client?
A) "Do you currently have a plan for killing yourself?"
B) "Why would you think about harming yourself?"
C) "Did you feel unsafe?"
D) "Do you ever think about hurting yourself?"
Answer: A
Explanation: A) It is helpful to recognize the client's current state, not a past state, by talking about depression and asking direct questions such as "Do you currently have a plan for killing yourself?" This is an effective type of questioning.
B) Asking why the client would hurt himself could be interpreted as being judgmental and may damage the nurse—client relationship.
C) Feeling unsafe is not associated with a suicide attempt.
D) Asking if the client thinks about self-harm is not sufficient. The nurse needs to ask if the client has a plan for suicide.
Page Ref: 2006
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment
Learning Outcome: 28.D. Analyze the nurse's role in preventing and responding to patient suicide attempts. Apply the nursing process in providing culturally competent care to an individual at risk for suicide.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient at risk for suicide.

8) A nursing instructor is evaluating a student's knowledge regarding a client with suicidal thoughts. Which statement made by the student demonstrates an understanding regarding assessing a client with suicidal thoughts?
A) "I should attempt to make light of the circumstances."
B) "I should be indirect and respectful."
C) "I should not talk about suicide directly."
D) "I should directly acknowledge the situation."
Answer: D
Explanation: A) Nurses recognize the severity and finality of the client's decision and do not attempt to make light of the circumstances.
B) Individuals who are experiencing suicidal ideation will not respect a restrained approach.
C) It is a common misconception that talking about suicide directly could cause the client to act in a suicidal manner, but this is not true.
D) Individuals who are experiencing suicidal ideation will respect direct acknowledgment of the situation.
Page Ref: 2006
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Evaluation
Learning Outcome: 28.D. Analyze the nurse's role in preventing and responding to patient suicide attempts. Apply the nursing process in providing culturally competent care to an individual at risk for suicide.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient at risk for suicide.

9) Which neurotransmitter change is frequently associated with suicide?
A) Increase in serotonin
B) Decrease in serotonin
C) Increase in dopamine
D) Decrease in dopamine
Answer: B
Explanation: A) Increased serotonin is not associated with suicide.
B) The most commonly studied neurotransmitter thought to be connected to suicide is serotonin. Suicidal individuals have been found to have decreased levels of serotonin, which can cause increased impulsivity and suicidal behavior.
C) Dopamine is not the neurotransmitter associated with suicide.
D) Dopamine is not the neurotransmitter associated with suicide.
Page Ref: 2001
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 28.D. Analyze the nurse's role in preventing and responding to patient suicide attempts. Describe the pathophysiology of suicide.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient at risk for suicide.

10) The nurse is caring for several clients who have plans to commit suicide. Which plan does the nurse identify as being most lethal?
A) The individual who plans to use a mild overdose of pharmaceuticals
B) The individual who plans to jump off a tall building
C) The individual who plans to jump off a bridge into a river
D) The individual who plans to slit across one wrist
Answer: B
Explanation: A) Individuals who would like to die but really just want people to know how unhappy they are will often use less mortal means such as a mild overdose of pharmaceuticals.
B) Individuals who have only death in mind when attempting suicide will usually use a gun, hang themselves, or jump from a tall building, because these methods are more likely to case mortal injuries.
C) Individuals who would like to die but really just want people to know how unhappy they are will often use less mortal means such as jumping off a bridge into a river.
D) Individuals who would like to die but really just want people to know how unhappy they are will often use less mortal means such as slitting one wrist.
Page Ref: 2001-2002
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment
Learning Outcome: 28.D. Analyze the nurse's role in preventing and responding to patient suicide attempts. Describe the etiology of suicide.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient at risk for suicide.

11) An older adult recently diagnosed with Alzheimer disease is a new widower. The client reports poor sleep, poor appetite, and lack of socialization because of issues with driving. Which problem should the nurse prioritize for this client's care?
A) Ineffective planning for activities
B) Grieving
C) Risk for loneliness
D) Risk of suicide
Answer: D
Explanation: A) The client has more issues than ineffective planning for activities.
B) Grieving may not be the priority for this client.
C) The client has more issues than loneliness.
D) Risk factors for suicide that this client displays are older age, male client, symptoms of depression, death of a close loved one, and diagnosis of a terminal illness. Older adults have a higher rate of success when attempting suicide because they tend to use more lethal means. The risk of suicide is the priority problem for this client.
Page Ref: 2002, 2007
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Diagnosis
Learning Outcome: 28.D. Analyze the nurse's role in preventing and responding to patient suicide attempts. Differentiate care of patients at risk for suicide across the lifespan.
MNL LO: Demonstrate understanding of the concept of mood and affect in the care of a patient at risk for suicide.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 29 Self

The Concept of Self

1) A client explains that she is experiencing high stress levels because her mornings are so hectic. She tells the nurse that before she arrives at work each morning, she needs to dress and feed her children, drop them off at daycare, and begin preparations for that evening's dinner. Based on this information, the nurse should anticipate that the client will require care related to which issue?
A) Self-esteem
B) Role mastery
C) Role conflict
D) Role ambiguity
Answer: C
Explanation: A) Self-esteem is the degree to which individuals approve of, value, or like themselves.
B) Role mastery occurs when individuals' behaviors within a role meet or exceed predetermined expectations.
C) When role-related expectations clash or are incongruent, role conflict may occur. This client is expected to be at work, care for her children, and make dinner, all within a limited window of time–a situation that could contribute to role conflict.
D) Role ambiguity occurs when individuals lack clarity regarding the expectations, behaviors, or demands associated with fulfilling a given role.

Page Ref: 2019
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 29.1. Analyze the psychosocial processes related to self-concept.
MNL LO: Analyze the concept of self and its application to nursing care.

2) A client reports feeling pressure to spend every Sunday with parents. However, the client's spouse does not participate and stays at home waiting for the client to return. Which element is determining the client's self-concept?
A) Family and culture
B) History of successes and failures
C) Stressors
D) Resources
Answer: A
Explanation: A) The client is conflicted because the client's parents have one set of expectations and the spouse has another. This conflict will adversely affect the client's self-concept.
B) A history of successes and failures can impact self-concept. People with a history of failures tend to see themselves as failures and view life in a negative way. Those with a history of successes often have a positive self-concept and view their lives as successful.
C) Stressors are events that cause an individual to either become stronger or respond in a maladaptive way.
D) Resources can be internal or external. Internal resources include confidence and values; external resources include support networks, finances, and organizations.
Page Ref: 2018
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 29.4. Outline the relationship between self-concept and other concepts.
MNL LO: Analyze the concept of self and its application to nursing care.

3) The nurse is teaching the parent of a 2-year-old client about steps to take to foster the child's self-esteem. Which statement by the parent indicates that more education is needed?
A) "At this stage, my most important job as a parent is to ensure that my child does not fail at completing new tasks."
B) "I should provide my child with an environment that is safe yet still allows for active exploration."
C) "My child needs to be permitted to learn from mistakes."
D) "Toddlers who feel confident about their ability to act independently are more likely to develop healthy self-esteem."
Answer: A
Explanation: A) Between the ages of 1 and 3, children will begin to assert their independence, develop skills, and engage in activities that promote growing independence and autonomy. Parents need to allow toddlers active exploration within an encouraging environment that is tolerant of failure; thus, the parent's statement that the child should not be permitted to fail at new tasks indicates a need for further education.
B) Parents need to allow toddlers active exploration within an encouraging environment that is tolerant of failure.
C) Parents need to allow toddlers to learn from mistakes.
D) The nurse should emphasize that the primary parental task at this stage is to foster independence while avoiding criticism of failures. By bolstering toddlers' self-esteem, parents will support children in acquiring increased independence, thus allowing them to become more confident and secure in their own ability to navigate in the world.
Page Ref: 2021
Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 29.1. Analyze the psychosocial processes related to self-concept.
MNL LO: Analyze the concept of self and its application to nursing care.

4) During an assessment, a client says, "I can't stand my mother" and "I always do what she wants me to do because I can't do anything right anyway." The nurse should use this information when determining which item during the client assessment?
A) Personal identity
B) Role performance
C) Self-esteem
D) Body image
Answer: C
Explanation: A) Personal identity would be assessed by asking the client to describe personal characteristics and self-concept.
B) Role performance would be assessed by asking the client about the different roles and satisfaction with each of these roles.
C) The client is critical of the mother, verbalizes feelings of helplessness by the statements and is critical of self, as evidenced by the statement of not being able to do anything right. These findings should all contribute to the nurse's assessment of the client's self-esteem.
D) Body image would be assessed by asking the client to explain personal feelings about appearance.
Page Ref: 2022
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 29.6. Differentiate common assessment procedures used to examine the individual's self-concept.
MNL LO: Analyze the concept of self and its application to nursing care.

5) An adult client says, "No matter what I do, I never can make my parents happy." Which action by the nurse may enhance the client's self-concept?

A) Suggesting that the client reduce the amount of time spent with parents

B) Reminding the client of having an education and a good marriage

C) Suggesting that the client turn the tables by expressing the same dissatisfaction with the parents

D) Telling the client that as an adult, listening to parents is not required

Answer: B

Explanation: A) Suggesting the client reduce the amount of time spent with parents is an inappropriate response and will not help the client identify strengths.

B) To improve or support the client's self-concept, the nurse needs to help the client identify strengths. Reminding the client about education, career, and marriage will help identify those strengths.

C) Suggesting the client express dissatisfaction with the parents is an inappropriate response and will not help the client identify strengths.

D) Telling the client of being too old to be listening to the parents is an inappropriate response and will not help the client identify strengths.

Page Ref: 2018

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation

Learning Outcome: 29.6. Analyze independent interventions nurses can implement for patients with alterations in self-concept.

MNL LO: Analyze the concept of self and its application to nursing care.

6) An older adult client recognizes the need for help with personal care at home yet does not want to move to a nursing home or assisted living facility. Which action by the nurse would best assist this client?
A) Reminding the client that physical strength will grow weaker at home until a nursing home is required
B) Suggesting that the client move in with adult children
C) Recommending to the physician that the client be admitted to a nursing home immediately
D) Referring the client to a personal care assistant who can help with activities of daily living
Answer: D
Explanation: A) Telling the client that progressive weakness will eventually make nursing home care inevitable will harm this client's already damaged self-esteem.
B) Suggesting that the client move in with children does not strengthen the client's feelings of self-worth or promote a healthy self-concept.
C) Suggesting the client be admitted to a nursing home does not strengthen the client's feelings of self-worth or promote a healthy self-concept.
D) The nurse needs to help strengthen this client's self-esteem. To best do this, the nurse should recommend a personal care assistant to help the client with activities of daily living.
Page Ref: 2020
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe client care. | Nursing Process: Implementation
Learning Outcome: 29.5. Explain the promotion of healthy self-concept.
MNL LO: Analyze the concept of self and its application to nursing care.

7) To evaluate a client's personal identity, the nurse should consider which three aspects of the client's self?

A) Ideal self, private self, and public self
B) Ideal self, real self, and public self
C) Authentic self, presented self, and perceived self
D) Real self, goal self, and private self

Answer: B

Explanation: A) Private self is not an aspect of personal identity.

B) Personal identity can be evaluated from the standpoint of three aspects of self: the ideal self, the real self, and the public self. The ideal self reflects the qualities an individual believes they should possess, as well as those they aspire to develop. The real self represents an individual's perceived true self; it may include observations about self or self-perceived qualities that the individual hides from others or does not readily share. The public self is formed on the basis of how the individual wishes to be perceived by others.

C) Authentic self is not an aspect of personal identity.

D) Goal self is not an aspect of personal identity.

Page Ref: 2018

Cognitive Level: Remembering

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 29.1. Analyze the psychosocial processes related to self-concept.

MNL LO: Analyze the concept of self and its application to nursing care.

8) The nurse is providing care to an adolescent client who has a history of vomiting after eating. Which diagnostic tests should the nurse anticipate when providing care to this client? **Select all that apply.**

A) Complete blood count
B) Serum electrolytes
C) Blood urea nitrogen (BUN) and creatinine
D) Urine drug screen
E) Barium enema

Answer: A, B, C

Explanation: A) A history of vomiting after eating is a clinical manifestation of an eating disorder. When caring for a client who is suspected of having an eating disorder, the nurse should anticipate the need for a complete blood count.

B) A history of vomiting after eating is a clinical manifestation of an eating disorder. When caring for a client who is suspected of having an eating disorder, the nurse should anticipate the need for serum electrolytes.

C) A history of vomiting after eating is a clinical manifestation of an eating disorder. When caring for a client who is suspected of having an eating disorder, the nurse should anticipate the need for BUN, and creatinine levels.

D) A urine drug screen would not be part of standard care for a client with a suspected eating disorder.

E) A barium enema would not be part of standard care for a client with a suspected eating disorder.

Page Ref: 2023, 2029

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 29.6. Differentiate common assessment procedures used to examine the individual's self-concept.

MNL LO: Analyze the concept of self and its application to nursing care.

9) A student nurse is asked to recall the questions included in the SCOFF questionnaire. Which questions identified by the student nurse are appropriate? **Select all that apply.**
A) Do you believe yourself to be fat when others say you are too thin?
B) Would you say that food dominates your life?
C) Do you worry you have lost control over how much you eat?
D) Do you make yourself sick because you feel uncomfortably full?
E) Have you recently lost more than 1 pound in a 3-month period?
Answer: A, B, C, D
Explanation: A) Do you believe yourself to be fat when others say you are too thin? is a question on the SCOFF questionnaire.
B) Would you say that food dominates your life? is a question on the SCOFF questionnaire.
C) Do you worry you have lost control over how much you eat? is a question on the SCOFF questionnaire.
D) Do you make yourself sick because you feel uncomfortably full? is a question on the SCOFF questionnaire.
E) Have you recently lost more than 1 pound in a 3-month period? is not a question included in the SCOFF questionnaire.
Page Ref: 2027
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 29.6. Differentiate common assessment procedures used to examine the individual's self-concept.
MNL LO: Analyze the concept of self and its application to nursing care.

10) A clinic nurse is providing care for several clients. Which client is at the highest risk for anorexia nervosa?
A) A 16-year-old Hispanic female client
B) A 21-year-old Hispanic male client
C) A 16-year-old non-Hispanic, White female client
D) A 22-year-old non-Hispanic, White male client
Answer: C
Explanation: A) Anorexia nervosa is not prevalent among Hispanic, female adolescents.
B) Anorexia nervosa is most prevalent among Hispanic males.
C) Although eating disorders can impact individuals at any age, adolescents and young adults are most often diagnosed with these disorders. In the United States, among adolescents and teens between the ages of 13 and 17, an estimated 2.7% have an eating disorder. Anorexia nervosa is most prevalent among non-Hispanic, White adolescents.
D) Compared to boys, girls are more than twice as likely to develop an eating disorder.
Page Ref: 2024
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 29.3. Differentiate alterations in self-concept.
MNL LO: Analyze the concept of self and its application to nursing care.

11) Which question would best help the nurse assess a client's global self-esteem?
A) "What do you consider your greatest personal strength?"
B) "What do you like least about yourself?"
C) "How satisfied are you with yourself and your life so far?"
D) "Do you consider yourself a hard-working person?"
Answer: C
Explanation: A) This question would help gauge the client's specific self-esteem.
B) This question would gauge the client's specific self-esteem.
C) Global self-esteem is the degree to which an individual likes themself overall, as a whole being. Of the questions listed here, only "How satisfied are you with yourself and your life so far?" would help the nurse assess a client's global self-esteem.
D) This question would assess the client's specific self-esteem.
Page Ref: 2028
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 29.6. Differentiate common assessment procedures used to examine the individual's self-concept.

MNL LO: Analyze the concept of self and its application to nursing care.

Exemplar 29.A Feeding and Eating Disorders

1) The nurse is providing care to a preadolescent client who was recently diagnosed with bulimia nervosa. The client's mother states, "I am very weight and exercise conscious, and I try to ensure my children stay in shape and eat well so that they can succeed in life. I have no idea how my daughter developed bulimia. She must have inherited a genetic tendency for bulimia from her birth mother." Based on this data, which conclusion by the nurse is the most appropriate?
A) The mother's focus on diet, exercise, and achievement fostered the client's eating disorder.
B) The client must have inherited a genetic predisposition for eating disorders.
C) The client must have a neurotransmitter abnormality.
D) The mother is setting a good example for the client with her eating and exercise habits.
Answer: A
Explanation: A) Many families of clients with eating disorders are achievement and performance oriented, with high ambition for the success of all members. In these families, body shape is frequently related to success, and a strong emphasis is placed on physical appearance and fitness. A family focus on professional achievement as well as on food, diet, exercise, and weight control may become obsessive and contribute to the development of eating disorders among one or more family members, as appears to be the case in this client's family.
B) There is not enough information to determine whether the client does or does not have a genetic predisposition to an eating disorder.
C) There is not enough information to determine whether the client does or does not have a neurotransmitter abnormality.
D) The client's mother is not setting a good example by being overly focused on eating and exercise.

Page Ref: 2033
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 29.A. Analyze feeding and eating disorders and how they relate to self. Compare the risk factors and prevention of feeding and eating disorders.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with feeding and eating disorder.

2) During a routine physical examination, a preadolescent client tells the nurse, "I am too fat, and I'm going to do whatever I can to look like the girls on the cover of fashion magazines." The nurse should plan care for this client based on which risk factor for eating disorders?

A) A desire for a long-term profession
B) Societal influences on body weight
C) Unrealistic expectations
D) Family influences on body weight

Answer: B

Explanation: A) The client may or may not be expressing a desire for a long-term profession.
B) Risk factors for the development of eating disorders include female gender, age, and societal influences, including media stereotypes. This client is a preadolescent female who wants to look like the girls on the covers of fashion magazines; therefore, societal influences are clearly contributing to her risk for eating disorders.
C) The client may be demonstrating unrealistic expectations; however, her main risk factors are her age, gender, and desire to look like the models in fashion magazines.
D) No information is given about family influences on the client's body weight.

Page Ref: 2033
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 29.A. Analyze feeding and eating disorders and how they relate to self. Compare the risk factors and prevention of feeding and eating disorders.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with feeding and eating disorder.

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3) The nurse is providing care to a client who is diagnosed with bulimia. Which clinical manifestations does the nurse anticipate when conducting the client's physical assessment? **Select all that apply.**

A) Increased urine output
B) Hoarseness when speaking
C) Poor skin turgor
D) Low body temperature
E) Elevated blood pressure

Answer: B, C

Explanation: A) Increased urine output is not associated with bulimia.
B) Physical signs of bulimia nervosa include hoarseness and esophagitis.
C) Physical signs of bulimia nervosa include poor skin turgor.
D) Low body temperature is not associated with bulimia.
E) Elevated blood pressure is not associated with bulimia.

Page Ref: 2036-2037

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 29.A. Analyze feeding and eating disorders and how they relate to self. Identify the clinical manifestations of feeding and eating disorders.

MNL LO: Demonstrate understanding of the concept of self in the care of a patient with feeding and eating disorder.

4) A client who has been admitted with an eating disorder tells the nurse, "No matter what I do, I continue to be fat." Which problem should the nurse use when planning care for this client?
A) Inadequate coping skills
B) Disturbed body image
C) Impaired tissue integrity
D) Lack of knowledge
Answer: B
Explanation: A) There is not enough information to determine whether the client does or does not have inadequate coping skills.
B) The problem that best supports this client's needs is disturbed body image.
C) The nurse cannot determine whether the client has impaired tissue integrity based on the information in the client's statement.
D) There is not enough information to determine whether the client does or does not have a lack of knowledge.
Page Ref: 2043
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | Nursing Process: Diagnosis
Learning Outcome: 29.A. Analyze feeding and eating disorders and how they relate to self. Apply the nursing process in providing culturally competent care to an individual with a feeding and eating disorder.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with feeding and eating disorder.

5) A client tells the nurse that the thought of eating makes her anxious and nervous, so she just avoids eating altogether. Which action would be highest priority when planning care for this client?
A) Providing instruction on the role of nutrition in normal menstruation
B) Providing instruction on the importance of nutrition for vital signs and muscle tone
C) Undertaking interventions to address anxiety and feelings of being in control
D) Providing instruction on appropriate nutritional intake
Answer: C
Explanation: A) Instruction on nutrition and normal menstruation are not the priority for the client at this time.
B) Instruction on nutrition and functions such as vital signs and muscle tone are not the priority for the client at this time.
C) The client is articulating feelings of anxiety and nervousness regarding eating. The nurse needs to include interventions to address the client's anxiety and feelings of being in control so that the root cause of the eating disorder can be addressed.
D) Instruction on nutrition is not the priority for the client at this time.
Page Ref: 2035
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | Nursing Process: Evaluation
Learning Outcome: 29.A. Analyze feeding and eating disorders and how they relate to self. Apply the nursing process in providing culturally competent care to an individual with a feeding and eating disorder.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with feeding and eating disorder.

6) The nurse is providing care to a client who has been diagnosed with anorexia nervosa. Which assessment findings indicate that the client has met some of the treatment goals related to the disease process? **Select all that apply.**
A) The client is observed wearing wrinkled clothes, listening to a portable music device, and staring out the window.
B) The client states that her menstrual cycle is regular and she is learning to prepare meals.
C) The client's vital signs are within normal limits.
D) The client's current weight is 75% of normal after 2 years of treatment.
E) The client tells a parent that new jeans are needed before eating occurs.
Answer: B, C
Explanation: A) The client who is wearing wrinkled clothes and staring out the window is not demonstrating positive self-care behaviors and would benefit from additional intervention.
B) Evidence that the care provided to a client with anorexia nervosa has been successful includes having a regular menstrual cycle and learning to prepare meals.
C) Evidence that the care provided to a client with anorexia nervosa has been successful includes vital signs within normal limits.
D) The client whose weight is 75% of normal would need additional treatment.
E) The client who wants new jeans before eating is demonstrating manipulative behavior, and this is evidence that treatment has not been successful.
Page Ref: 2043
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 29.A. Analyze feeding and eating disorders and how they relate to self. Apply the nursing process in providing culturally competent care to an individual with a feeding and eating disorder.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with feeding and eating disorder.

7) An adolescent client who currently weighs 50% of expected body weight tells the nurse, "I get upset and can't eat because my mother is constantly forcing food on me." Which treatments are indicated for this client? **Select all that apply.**

A) Family-based psychotherapy
B) Hospitalization
C) Behavior modification
D) Medication to increase appetite
E) Placement with a foster family

Answer: A, B, C

Explanation: A) Family-based psychotherapy is indicated because the client feels a parent is forcing eating.

B) Indications for hospitalization are a loss of 25-30% of body weight. This client currently weighs 50% of expected body weight, so hospitalization is likely necessary.

C) Behavior modification techniques are used extensively in combination with counseling in the care of hospitalized clients with anorexia nervosa.

D) Medication to increase appetite is not an approved method of treatment for clients with anorexia nervosa.

E) Moving the client to a foster family is an extreme measure and might not help the problem.

Page Ref: 2040

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

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Learning Outcome: 29.A. Analyze feeding and eating disorders and how they relate to self. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with feeding and eating disorders.

MNL LO: Demonstrate understanding of the concept of self in the care of a patient with feeding and eating disorder.

8) The nurse is assessing a client with bulimia nervosa. Which assessment findings indicate that the client is dehydrated? **Select all that apply.**
A) Dry mouth
B) Hypertension
C) Concentrated urine
D) General weakness
E) Poor skin turgor
Answer: A, C, D, E
Explanation: A) A client who is dehydrated may exhibit a dry mouth.
B) Hypertension would not be a sign that the client is dehydrated.
C) A client who is dehydrated may exhibit concentrated urine.
D) A client who is dehydrated may exhibit general weakness.
E) A client who is dehydrated may exhibit poor skin turgor.
Page Ref: 2038
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 29.A. Analyze feeding and eating disorders and how they relate to self. Identify the clinical manifestations of feeding and eating disorders.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with feeding and eating disorder.

9) The nurse is providing care to a client diagnosed with bulimia. The healthcare provider has prescribed medication to help decrease the client's binging and purging behavior. Which medication classification should the nurse include in the teaching plan for this client?
A) Mood stabilizers
B) Antidepressants
C) Antipsychotics
D) Anxiolytics
Answer: B
Explanation: A) Mood stabilizers are not prescribed to treat bulimia.
B) The antidepressant fluoxetine (Prozac) is the only medication approved by the U.S. Food and Drug Administration for treating bulimia. This and other antidepressants may help individuals for whom depression and anxiety are at the root of bulimic behavior. Fluoxetine appears to lessen binging and purging behaviors, reduce the likelihood of relapse, and improve attitudes toward eating.
C) Antipsychotics are not used to treat bulimia.
D) Anxiolytics are not used to treat bulimia.
Page Ref: 2039-2040
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 29.A. Analyze feeding and eating disorders and how they relate to self. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with feeding and eating disorders.

MNL LO: Demonstrate understanding of the concept of self in the care of a patient with feeding and eating disorder.

10) A college student tells the nurse about being "out of control" with eating. The client states, "I am trying to keep my weight down so my mom doesn't call me fat. Usually, I make myself throw up after eating." Based on this data, the nurse should plan on providing care for which disorder?
A) Binge-eating disorder
B) Anorexia nervosa
C) Bulimia nervosa
D) Purging disorder
Answer: C
Explanation: A) Binge-eating disorder is often associated with obesity and is characterized by binging twice a week for at least 6 months.
B) Anorexia nervosa is characterized by extreme perfectionism, weight fear, significant weight loss, body image disturbances, strenuous exercising, and peculiar food-handling patterns.
C) In bulimia nervosa, binge eating is followed by purging.
D) In purging disorder, purging is done without the ingestion of food beforehand.
Page Ref: 2035-2036
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 29.A. Analyze feeding and eating disorders and how they relate to self. Identify the clinical manifestations of feeding and eating disorders.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with feeding and eating disorder.

11) An experienced nurse practitioner is teaching a student nurse about feeding and eating disorders in the pediatric population. Which statement from the student nurse indicates that more education is necessary?
A) "Avoidant/restrictive food intake disorder, or ARFID, is the most common eating disorder among children."
B) "In recent years, eating disorders have become more common in the pediatric population."
C) "Many children are picky eaters, but few of them satisfy the diagnostic criteria for ARFID."
D) "Eating disorders are overdiagnosed in children because providers often fail to distinguish picky eating from true ARFID."
Answer: D
Explanation: A) ARFID is the most significant eating disorder diagnosis among children.
B) In recent years, higher rates of eating disorders have been observed in younger children, boys, and minority groups than in years past.
C) The ARFID diagnosis eliminates picky eaters by identifying only those children with clinically significant restrictive eating problems that result in persistent failure to meet the child's nutritional and/or energy needs.
D) Eating disorders remain underdiagnosed in the pediatric population. The nurse's statement that eating disorders are overdiagnosed in children indicates the need for further education.
Page Ref: 2041
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 29.A. Analyze feeding and eating disorders and how they relate to self. Differentiate care of patients with feeding and eating disorders across the lifespan.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with feeding and eating disorder.

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12) The nurse is caring for a pregnant client who has a history of bulimia nervosa. Which statement should the nurse include when counseling this client about the potential effects of pregnancy on eating disorder?
A) "In some women with a history of eating disorders, pregnancy can lead to new or renewed onset of binge eating."
B) "Only a tiny fraction of women with bulimia continue to engage in disordered eating during pregnancy."
C) "Women with a history of bulimia or anorexia are at increased risk for pica during pregnancy."
D) "Engaging in disordered eating while pregnant can harm you, but it is unlikely to affect the health of your fetus."
Answer: A
Explanation: A) The nurse would be correct in stating that women with a history of eating disorders are at risk for new or renewed onset of binge eating during pregnancy. Research has found that pregnancy poses a risk for the onset of binge eating disorder (BED) in vulnerable individuals, occurring in nearly 1 in every 20 women.
B) A substantial proportion of women who have prepregnancy eating disorders continue to engage in disordered eating while pregnant.
C) A history of eating disorders does not appear to increase the likelihood of pica during pregnancy.
D) Disordered eating during pregnancy can result in negative fetal outcomes, such as low birth weight.
Page Ref: 2041-2042
Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 29.A. Analyze feeding and eating disorders and how they relate to self. Differentiate care of patients with feeding and eating disorders across the lifespan.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with feeding and eating disorder.

13) In an adult client, the presence of lanugo and dry, brittle nails is suggestive of which condition?
A) Bulimia nervosa
B) Binge-eating disorder
C) Pica
D) Anorexia nervosa
Answer: D
Explanation: A) Lanugo is not associated with bulimia nervosa.
B) Lanugo is not associated with binge-eating disorder.
C) Lanugo is not associated with pica.
D) On physical assessment, patients with anorexia nervosa will appear emaciated. Their skin may be dry and covered by a fine layer of hair called lanugo, and their nails will appear to be dry and brittle. Although lanugo is a normal finding in newborn clients, it is nearly always associated with anorexia nervosa in adults.
Page Ref: 2043
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 29.A. Analyze feeding and eating disorders and how they relate to self. Identify the clinical manifestations of feeding and eating disorders.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with feeding and eating disorder.

14) Why is the presence of dental caries and enamel erosion more suggestive of bulimia nervosa than of anorexia nervosa?
A) Unlike clients with anorexia nervosa, clients with bulimia nervosa are unlikely to consume sufficient amounts of calcium and other bone-building nutrients due to their restricted food intake.
B) Unlike clients with anorexia nervosa, clients with bulimia nervosa tend to eat large amounts of sugar, which promotes tooth decay.
C) Unlike clients with anorexia nervosa, clients with bulimia nervosa often purge by vomiting, which means their teeth are frequently exposed to the highly acidic contents of the stomach.
D) Unlike clients with anorexia nervosa, clients with bulimia nervosa tend to consume large amounts of laxatives, which can damage the oral cavity.
Answer: C
Explanation: A) Both clients with bulimia and clients with anorexia experience nutritional deficiencies.
B) Although clients with bulimia are more likely to consume sugar, this is not the primary cause of the tooth damage frequently associated with this disorder.
C) Bulimia nervosa involves purging behaviors, whereas anorexia nervosa does not. Many clients with bulimia purge by inducing vomiting. Because the stomach contents are highly acidic, frequent vomiting can lead to enamel erosion and tooth decay.
D) Laxative use does not cause tooth decay.
Page Ref: 2043
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 29.A. Analyze feeding and eating disorders and how they relate to self. Identify the clinical manifestations of feeding and eating disorders.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with feeding and eating disorder.

Exemplar 29.B Personality Disorders

1) An adolescent client tells the nurse about planning to fight recent charges of shoplifting because she was only taking what was rightfully hers. Which trait associated with personality disorders is this client exhibiting?
A) Lying
B) Narcissism
C) Projection
D) Manipulation
Answer: B
Explanation: A) The client may be lying to the nurse but lying is not a key trait associated with personality disorders.
B) Clinical manifestations commonly seen in individuals with personality disorders include narcissism, manipulation, and impulsiveness. A client who states that she was only taking what was rightfully hers is demonstrating narcissism, which is the belief that one is the superior to others and therefore entitled to certain things.
C) The client's statement does not indicate projection, nor is projection a common characteristic in individuals with personality disorders.
D) Manipulation is controlling behavior that exploits others for personal gain. Although this client may engage in manipulative behavior, she is not demonstrating manipulation in this statement.
Page Ref: 2047
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 29.B. Analyze personality disorders as they relate to self. Describe the pathophysiology of personality disorders.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with personality disorder.

2) A client tells the nurse, "My mother spent many years in a mental institution, and my father would abuse me when my mother was not around." Based on this information, the client is at greatest risk for developing which condition?
A) A personality disorder
B) Poor relationships with individuals of the opposite sex
C) An eating disorder
D) Substance abuse
Answer: A
Explanation: A) Risk factors for the development of personality disorders include a family history of mental illness, a history of abuse, instability in family life, and a personal history of other mental illnesses. The client's statement mentions several of these risk factors.
B) Based on the information presented, this client is not necessarily at high risk for poor relationships with individuals of the opposite sex.
C) Based on the information presented, this client is not necessarily at high risk for an eating disorder.
D) Based on the information presented, this client is not necessarily at high risk for substance abuse.
Page Ref: 2049
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | | Nursing Process: Assessment
Learning Outcome: 29.B. Analyze personality disorders as they relate to self. Compare the risk factors and prevention of personality disorders.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with personality disorder.

3) A client who was admitted for treatment of a personality disorder is observed pulling another client's hair and pushing clients out of their chairs. Which intervention is the priority for this client?
A) Removing the client from the room and addressing the behavior privately
B) Establishing a therapeutic nurse-client relationship
C) Placing the client in a jacket restraint
D) Asking the client what purpose is served by disrupting others
Answer: A
Explanation: A) Priorities of care for a client with a personality disorder include safety, managing crisis, setting limits, and improving socialization. The best intervention would be for the nurse to remove the disruptive client from the room and address the behavior privately.
B) Because of the nature of personality disorders, it may be difficult to form a therapeutic nurse-client relationship, so this should not be the nurse's main focus at this time.
C) Placing the client in a jacket restraint is not indicated in response to this behavior.
D) The nurse should not confront the client by asking what purpose is served by disrupting others.
Page Ref: 2057
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 29.B. Analyze personality disorders as they relate to self. Apply the nursing process in providing culturally competent care to an individual with a personality disorder.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with personality disorder.

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4) A client who has been diagnosed with a personality disorder tells the nurse, "Sometimes I daydream that I go home and kill my family." Which problem is the priority for this client?

A) Inadequate coping

B) Lack of knowledge

C) Potential for violence

D) Family problems

Answer: C

Explanation: A) The client might have problems coping; however, this is not the priority problem.

B) There is no evidence that the client lacks knowledge.

C) A client who has been diagnosed with a personality disorder and admits to daydreaming about killing family has a potential for violence. This is the priority problem.

D) There might be family problems; however, this is not the priority.

Page Ref: 2015

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 29.B. Analyze personality disorders as they relate to self. Apply the nursing process in providing culturally competent care to an individual with a personality disorder.

MNL LO: Demonstrate understanding of the concept of self in the care of a patient with personality disorder.

5) The nurse is planning care for a client who has been diagnosed with antisocial personality disorder. Which goals address the client's antisocial behavior? **Select all that apply.**
A) The client will share meals with others in the community dining area.
B) The client will interact socially with others.
C) The client will engage in individual therapy without disruptions.
D) The client will take all medications as prescribed.
E) The client will refrain from attention-seeking behavior.
Answer: A, B
Explanation: A) This client is demonstrating antisocial behavior. Goals that address antisocial behavior include sharing meals in the community dining area.
B) This client is demonstrating antisocial behavior. Goals that address antisocial behavior include interacting socially with others.
C) Engaging in therapy is not a goal for this disorder.
D) Taking medications is not a goal for this disorder.
E) Refraining from attention-seeking behavior is not a goal for this disorder.
Page Ref: 2050
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 29.B. Analyze personality disorders as they relate to self. Apply the nursing process in providing culturally competent care to an individual with a personality disorder.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with personality disorder.

6) The nurse is providing care to a client who has been diagnosed with a personality disorder. Which finding indicates that the treatment plan has been beneficial for this client?
A) The client has ceased self-mutilating behavior and bathes once a week.
B) The client eats sporadically and reports being told she does not deserve to eat.
C) The client asks others for money because the client's money was stolen.
D) The client sits with others in the lounge area conversing about current affairs.
Answer: D
Explanation: A) Bathing once a week does not indicate that treatment has been beneficial.
B) Sporadic eating and denying food does not indicate that treatment has been beneficial.
C) Asking for money does not indicate that treatment has been beneficial.
D) For clients with personality disorders, improvement will be achieved slowly. The client who is observed sitting with others in the lounge area conversing about current affairs is showing indications that treatment has been beneficial.
Page Ref: 2058
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 29.B. Analyze personality disorders as they relate to self. Apply the nursing process in providing culturally competent care to an individual with a personality disorder.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with personality disorder.

7) A client is admitted with behavior consistent with borderline personality disorder. Which intervention should the nurse anticipate for this client?
A) Exercise therapy
B) Vitamin B_{12} injections
C) Occupational therapy
D) Dialectical behavior therapy
Answer: D
Explanation: A) Exercise therapy is not known to improve borderline personality disorder.
B) Vitamin B_{12} injections might be indicated if the client demonstrates depressive episodes.
C) Occupational therapy is not known to improve borderline personality disorder.
D) Dialectical behavior therapy (DBT) is a cognitive and behavioral therapy used in the treatment of borderline personality disorder. DBT has been shown to decrease suicidal behavior, hospitalization, and treatment dropout while improving interpersonal functioning and anger management. This is the intervention most likely to be used with this client.
Page Ref: 2023, 2055
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 29.B. Analyze personality disorders as they relate to self. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with personality disorders.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with personality disorder.

8) A nurse working on the behavioral health unit is developing a plan of care for a client. The client does not interact with others, refuses to attend group sessions, and has a history of throwing things at other clients. Which problem is the priority for this client?
A) Inadequate coping skills
B) Potential for violence
C) Social isolation
D) Anxiety
Answer: B
Explanation: A) There is no evidence that the client has inadequate coping skills.
B) Potential for violence is the priority problem because ensuring the safety of others is imperative.
C) Social isolation is not a priority problem for this client.
D) Anxiety is not a priority problem for this client.
Page Ref: 2057
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 29.B. Analyze personality disorders as they relate to self. Apply the nursing process in providing culturally competent care to an individual with a personality disorder.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with personality disorder.

9) A nurse working on the behavioral health unit is caring for a client with histrionic personality disorder. Which types of behaviors should the nurse anticipate when assessing this client? **Select all that apply.**
A) Flamboyant behaviors
B) Dramatic behaviors
C) Competitive behaviors
D) Arrogant behaviors
E) Manipulative behaviors
Answer: A, B
Explanation: A) Clients with histrionic personality disorder tend to be flamboyant.
B) Clients with histrionic personality disorder tend to be dramatic.
C) Competitiveness is more commonly associated with narcissistic personality disorder.
D) Arrogance is more commonly associated with narcissistic personality disorder.
E) Manipulative behaviors are more commonly associated with narcissistic personality disorder.
Page Ref: 2050
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 29.B. Analyze personality disorders as they relate to self. Identify the clinical manifestations of personality disorders.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with personality disorder.

10) The nurse is providing care to a client who has been diagnosed with a personality disorder. Which treatment options should the nurse anticipate for this client? **Select all that apply.**
A) Antipsychotic medication
B) Antidepressant medication
C) Cognitive-behavioral therapy
D) Nutritional counseling
E) Weight management program
Answer: A, B, C
Explanation: A) For a client who has been diagnosed with a personality disorder, the nurse would anticipate antipsychotic medication to be prescribed.
B) For a client who has been diagnosed with a personality disorder, the nurse would anticipate antidepressant medication to be prescribed.
C) For a client who has been diagnosed with a personality disorder, the nurse would anticipate cognitive-behavioral therapy to be prescribed.
D) Nutritional counseling would be more appropriate for a client with an eating disorder.
E) Weight management program would be more appropriate for a client with an eating disorder.
Page Ref: 2051
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 29.B. Analyze personality disorders as they relate to self. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with personality disorders.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with personality disorder.

11) An experienced nurse is teaching a student nurse about personality disorders in the older adult population. Which statement by the student nurse would indicate a need for further education?
A) "In some older adults, borderline personality disorder remits with age."
B) "In older adults, loss of a significant support person sometimes exacerbates symptoms and leads individuals to seek treatment."
C) "Antisocial personality disorder tends to worsen as a person moves from middle age into older adulthood."
D) "Among older adults with personality disorders, the risk of suicide tends to decline with age."
Answer: C
Explanation: A) In some individuals, borderline personality disorders remit with age.
B) Loss of a support person can exacerbate symptoms in an older client.
C) In some individuals, antisocial and borderline personality disorders become less evident or remit with age; thus, the student nurse's statement about antisocial personality disorder indicates a need for further education.
D) The risk for suicide does tend to decline with age.
Page Ref: 2056
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 29.B. Analyze personality disorders as they relate to self. Differentiate care of patients with personality disorders across the lifespan.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with personality disorder.

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12) The parents of an adolescent client tell the nurse that their daughter is very shy, exhibits intense anxiety about new people and situations, and tends to internalize negative comments from her peers. They ask the nurse whether they should be concerned about this behavior. Which response should the nurse make?
A) "All of these behaviors are strongly associated with avoidant personality disorder. I'd suggest you take your daughter to a psychologist as soon possible."
B) "Your daughter may be exhibiting signs of dependent personality disorder, but this condition can't be formally diagnosed until she is an adult."
C) "This behavior is normal for adolescents, and your daughter will eventually grow out of it."
D) "A lot of these behaviors are developmentally appropriate to some degree, but if they persist or severely impair your daughter's ability to function, they may be suggestive of a personality disorder."
Answer: D
Explanation: A) These behaviors may actually be developmentally appropriate, so the nurse should not prematurely or inappropriately suggest that the client has a Cluster C disorder.
B) These are not behaviors of a dependent personality disorder.
C) There is no evidence that the client will outgrow these behaviors.
D) All of the behaviors described here are associated with avoidant personality disorder, which cannot be accurately diagnosed until a client has reached adulthood. Some individuals who are later diagnosed with Cluster C personality disorders (avoidant personality disorder and dependent personality disorder) will become increasingly shy during adolescence and early adulthood and avoid developing the social relationships characteristic of that developmental stage.
Page Ref: 2050

Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 29.B. Analyze personality disorders as they relate to self. Differentiate care of patients with personality disorders across the lifespan.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with personality disorder.

13) Which personality disorder is characterized by an inability to trust others; a rigid worldview that is often conspiratorial in nature; and the belief that other people's actions are based on ulterior motives?
A) Obsessive-compulsive personality disorder
B) Paranoid personality disorder
C) Schizoid personality disorder
D) Schizotypal personality disorder
Answer: B
Explanation: A) Obsessive-compulsive personality disorder is characterized by difficulty expressing emotions and fear of making mistakes.
B) Individuals with paranoid personality disorder (PPD) tend to demonstrate an inability to trust others. Actions and intentions of others are perceived as having an underlying theme of malevolence. From the suspicious, mistrusting vantage point of the individual with PPD, others are viewed as being deceptive and disloyal. Individuals with PPD often maintain rigid, inflexible worldviews and will reject logic or proof that contradicts their beliefs. Hypervigilance combined with certainty that others' actions are prompted by hidden motives can lead to isolation.
C) Schizoid personality disorder is characterized by solitary activities and disinterest in socialization.
D) Schizotypal personality disorder is characterized by bizarre behavior, appearance, and speech.
Page Ref: 2050
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment

Learning Outcome: 29.B. Analyze personality disorders as they relate to self. Identify the clinical manifestations of personality disorders.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with personality disorder.

14) Which manifestations would the nurse least likely observe in a client with a Cluster B personality disorder?
A) Dramatic behavior
B) Erratic behavior
C) Extreme fearfulness
D) Extremely emotionality
Answer: C
Explanation: A) Clients with Cluster B traits, which include antisocial, borderline, histrionic, and narcissistic personality disorders, may display dramatic behaviors.
B) Clients with Cluster B traits, which include antisocial, borderline, histrionic, and narcissistic personality disorders, may display erratic behavior.
C) Clients with Cluster C traits, which include avoidant, dependent, and obsessive-disorder personality disorders, may appear as anxious or fearful.
D) Clients with Cluster B traits, which include antisocial, borderline, histrionic, and narcissistic personality disorders, may display emotional behaviors.
Page Ref: 20251
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 29.B. Analyze personality disorders as they relate to self. Identify the clinical manifestations of personality disorders.
MNL LO: Demonstrate understanding of the concept of self in the care of a patient with personality disorder.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)

Module 30 Spirituality

The Concept of Spirituality

1) The nurse is assessing a client's spirituality. Which findings would suggest that the client experiences spirituality as a source of strength? **Select all that apply.**
A) The client uses the telephone to inform family members of an unwanted diagnosis.
B) The client reads spiritual material every evening.
C) The client asks to watch a religious service on television.
D) The client has no desire to meet with a chaplain.
E) The client believes in punishment in the afterlife.
Answer: B, C
Explanation: A) Discussing an unwanted diagnosis on the phone is unrelated to spirituality.
B) Regularly reading spiritual material is an action that suggests the client views spirituality as a source of strength.
C) Asking to watch a religious service on television is an action that suggests the client views spirituality as a source of strength.
D) Lack of interest in meeting with a chaplain might indicate spiritual distress, or it might indicate that the client either places little emphasis on spirituality or feels spirituality is a private matter.
E) Focusing on possible punishment in the afterlife would suggest that the client is experiencing spiritual distress.
Page Ref: 2067, 2070, 2078

Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 30.1. Distinguish between spiritual wellness and spiritual discomfort.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

2) While hospitalized, a client learns that a close friend has died suddenly. The client is crying and asking, "Why, God?" Which behavior is the client demonstrating?
A) Anger
B) Anxiety
C) Spiritual distress
D) Ineffective coping
Answer: C
Explanation: A) There is no evidence that the client's behavior is anger.
B) There is no evidence that the client's behavior is anxiety.
C) Clients who experience spiritual distress are challenged or unable to find meaning in life, peace, comfort, strength, connection to God or a higher power, or with friends and family, resulting in feelings of distress or suffering. Some may feel a disconnection from themselves.
D) There is no evidence that the client is experiencing ineffective coping.
Page Ref: 2067-2068
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 30.1. Distinguish between spiritual wellness and spiritual discomfort.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

3) The nurse is providing care to a client diagnosed with type 2 diabetes mellitus. The client wishes to take Communion but must fast for 1 hour prior to receiving it. Which action by the nurse is most appropriate?
A) Contact the healthcare provider to suggest an alternative form of nutrition because the client is refusing to eat or drink.
B) Provide the client with breakfast and morning medication and encourage the client to eat and take Communion some other time.
C) Find out when the hospital clergy will be distributing Communion and adjust the client's medications and breakfast accordingly.
D) Suggest that because the client is hospitalized, eating and drinking will not affect the Communion.
Answer: C
Explanation: A) The nurse should not contact the healthcare provider to suggest alternative forms of nutrition, because the client is not refusing to eat or drink but wants to delay eating and drinking until after Communion.
B) The nurse should not ignore the client's needs by providing medication and breakfast.
C) The nurse should follow the client's expressed wishes regarding spiritual care and should not pressure them to relinquish any of their beliefs or practices. To support the client's spiritual needs, the nurse should find out when Communion will be distributed and adjust the medications and breakfast accordingly.
D) The nurse should not suggest that eating and drinking will not affect Communion.
Page Ref: 2071
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Implementation
Learning Outcome: 30.2. Discuss how religious practices may impact nursing and health care.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

4) While assessing a client's spiritual needs, the nurse asks, "What spiritual beliefs are important to you?" This question represents which step of the SPIRIT assessment model?
A) Spiritual belief system
B) Personal spirituality
C) Implications for medical care
D) Ritual practices and restrictions
Answer: A
Explanation: A) Within the SPIRIT assessment model for spirituality, spiritual belief system is assessed by asking the question "What spiritual beliefs are important to you?"
B) Within the SPIRIT assessment model for spirituality, the question "What spiritual beliefs are important to you?" does not address personal spirituality.
C) Within the SPIRIT assessment model for spirituality, the question "What spiritual beliefs are important to you?" does not address implications for medical care.
D) Within the SPIRIT assessment model for spirituality, the question "What spiritual beliefs are important to you?" does not address ritual practices and restrictions.
Page Ref: 2077
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 30.3. Outline the relationship between spirituality and other concepts.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

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5) When receiving nursing care, the client states, "I drink a small glass of warm water mixed with the juice of one lemon every morning because it helps to heal my body." Which action by the nurse is appropriate when providing care to this client?
A) Tell the client that cold water is better metabolized by the body.
B) Instruct the client that lemon juice is really a dose of vitamin C that helps with healing.
C) Provide the warm water and juice of a lemon.
D) Suggest the client delay the water and lemon until after morning medications.
Answer: C
Explanation: A) The nurse should not suggest that cold water be used instead.
B) The nurse should not instruct the client about the benefits of lemon juice being vitamin C.
C) The nurse should follow the client's expressed wishes regarding spiritual care. To support the client's beliefs about healing, the nurse should provide the client with the warm water and lemon juice.
D) Asking the client to delay drinking the water and lemon juice will not support the client's spiritual needs.
Page Ref: 2067
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Respect the patient's dignity, uniqueness, integrity, and self-determination, and his or her own power and self-healing processes. | Nursing Process: Implementation

Learning Outcome: 30.6. Analyze the nurse's role in supporting the spiritual health of patients.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

6) Which questions are appropriate for the nurse to ask when assessing the spiritual beliefs of a client? **Select all that apply.**

A) "How will being sick interfere with your religious practices?"
B) "Would you like a visit from your spiritual counselor or the hospital chaplain?"
C) "Are any particular religious practices important to you?"
D) "How is your faith helpful to you?"
E) "Because you indicated you are Catholic, I suppose you fast every Friday?"

Answer: A, B, C, D

Explanation: A) Asking how being sick interferes with religious practices is appropriate for the nurse to ask a client during an admission assessment while assessing spiritual and religious beliefs.

B) Asking if the client would like a visit from a spiritual counselor is appropriate for the nurse to ask a client during an admission assessment while assessing spiritual and religious beliefs.

C) Asking if the client has any particular religious practices is appropriate for the nurse to ask a client during an admission assessment while assessing spiritual and religious beliefs.

D) Asking how faith is helpful to the client is appropriate for the nurse to ask a client during an admission assessment while assessing spiritual and religious beliefs.

E) The question related to fasting on Friday is inappropriate because it assumes that a client follows all the practices of the client's stated religion.

Page Ref: 2077-2078

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Assessment

Learning Outcome: 30.6. Analyze the nurse's role in supporting the spiritual health of patients.

MNL LO: Analyze the concept of spirituality and its application to nursing care.

7) The nurse is admitting a client to the oncology unit. During the admission assessment, when the nurse asks the client about religious preference, the client states, "I am an atheist." In which way should the nurse support this client?
A) Offer to pray with the client
B) Ask the chaplain to visit the client
C) Offer to discuss God with the client
D) Document the client's religious belief
Answer: D
Explanation:
A) The client does not believe in God. Offering to pray with the client is not supportive.
B) The client does not believe in God. Asking the chaplain to visit the client is not supportive.
C) The client does not believe in God. Offering to discuss God with the client is not supportive.
D) The client does not believe in God. The client's religious belief should be documented.
Page Ref: 2077
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Appreciate the patient as a whole person, with his or her own life story and ideas about the meaning of health or illness. | Nursing Process: Implementation
Learning Outcome: 30.6. Analyze the nurse's role in supporting the spiritual health of patients.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

8) The family members of a critically ill client tell the nurse, "We believe in the power of prayer. Prayer connects us all and makes us stronger. We will continue to pray that our loved one recovers." This statement suggests that the family is demonstrating which characteristic?
A) Good family support system
B) Spiritual well-being
C) Denial
D) Spiritual distress
Answer: B
Explanation: A) Although this statement indicates that the family turns to a higher power for support, it does not reveal anything about the family's overall support system.
B) Through their statement, the family members express the belief that they are connected by a higher power. They also say they draw strength from this belief. This is evidence of spiritual well-being.
C) The family may or may not be denying the client's health status.
D) Through their statement, the family members express the belief that they are connected by a higher power. They also say they draw strength from this belief. This is not spiritual distress.
Page Ref: 2067
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 30.1. Distinguish between spiritual wellness and spiritual discomfort.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

9) Prior to being discharged, a client tells the nurse, "I trust you and the rest of the medical team, and I think the prescribed treatment is going to work. I'm ready to embrace life, and I'm looking forward to celebrating the holiday season in a few months." Which behavior is this client demonstration?

A) Spiritual well-being
B) Denial
C) Conflict
D) Apprehension

Answer: A

Explanation: A) The client speaks of trusting relationships, hope, and a feeling of being alive and ready to embrace what the future brings. This suggests the client is in a state of spiritual well-being.

B) The client's statement is not suggestive of denial.

C) The client's statement is not suggestive of conflict about the future.

D) The client's statement is not suggestive of apprehension.

Page Ref: 2067

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Evaluation

Learning Outcome: 30.1. Distinguish between spiritual wellness and spiritual discomfort.

MNL LO: Analyze the concept of spirituality and its application to nursing care.

10) A client was recently diagnosed with alcoholic liver cirrhosis. During a regular checkup, the client tells the nurse, "This is God's punishment for all those parties I went to when I was younger." The nurse should recognize that this religious view could have a negative effect on which other nursing concept?
A) Addiction
B) Legal Issues
C) Stress and Coping
D) Digestion
Answer: C
Explanation: A) Negative expressions of religious coping include statements like "God is punishing me." If the client is addicted to alcohol, the diagnosis and religious belief may stimulate the client to give up alcohol, which would not be a negative effect.
B) There are no legal issues present due to this client's statement.
C) Clients can use religion as either a positive or a negative coping strategy.
D) This religious view is unlikely to affect the client's digestive processes, although the disease itself may reduce metabolism associated with digestion.
Page Ref: 2074
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 30.3. Outline the relationship between spirituality and other concepts.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

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11) The nurse is caring for a devout Muslim client who is near death. The nurse should be prepared for which request from the client related to religious beliefs?
A) Turn the client's head or body toward Mecca.
B) Have a spiritual leader perform the Anointing of the Sick.
C) Read the client the *Tibetan Book of the Dead*.
D) Perform a ritualistic bath for cleansing the body.
Answer: A
Explanation: A) Muslims who are dying often want their body or head turned toward Mecca, and they are encouraged to say the prayer recognizing their loyalty to Allah.
B) Roman Catholics may request having a spiritual leader perform the sacrament of Anointing of the Sick.
C) Tibetan Buddhists may read the *Tibetan Book of the Dead* within 7 days after death, but not before death.
D) Ritualistic bathing of the body is usually performed by some religions, including Muslims, after death, not before death.
Page Ref: 2073
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Planning
Learning Outcome: 30.2. Discuss how religious practices may impact nursing and health care.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

12) The nurse is caring for an 8-year-old client who has been in the hospital repeatedly due to complications from leukemia. The nurse understands that the family is very religious, and the client often speaks about God's care for her. Which age-appropriate nursing intervention should the nurse implement that can help the child express spirituality?
A) Help the child reminisce about fun experiences earlier in life.
B) Provide the child with tools to draw and color pictures.
C) Provide the child with tools to produce a music video.
D) Support parent-child bonding to encourage attachment.
Answer: B
Explanation: A) Reminiscing about the past is more appropriate for older adults.
B) Nurses can support the spiritual well-being of the child by age-appropriate activities that allow nonverbal expression of faith, including drawing, coloring, painting, play, or music, depending on the child's interests or energy level.
C) Producing a music video is more appropriate for adolescent clients.
D) Supporting parent-child bonding is more appropriate for infants.
Page Ref: 2075
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Implementation
Learning Outcome: 30.5. Summarize the development of spirituality across the lifespan.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

13) The nurse is caring for an older adult client with advanced dementia. The family often mentions that the client was very spiritual earlier in life and loved to sing. Which action could the nurse suggest to the family to help support the client's religious needs?
A) They should help the client reminisce about spiritual events early in life.
B) They should encourage the client to compose lyrics or write music to a new spiritual song.
C) They should sing some of their favorite songs to the client.
D) They should bring in a recording of some of the client's favorite spiritual songs for him to listen to.
Answer: D
Explanation: A) The client has dementia and may not recall spiritual events earlier in life.
B) The client has dementia. Composing lyrics or writing music would be more appropriate for an adolescent.
C) The client's favorite songs should be sung to the client.
D) One way that clients with dementia can worship is through various art forms, including music. This is an especially appropriate option for this client, given his history of spirituality and a love of singing. Letting the client listen to some of his favorite spiritual songs will give him an opportunity to enjoy an enriching spiritual experience without being pressured to participate, generate new ideas, or remember events from the past.
Page Ref: 2077
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Implementation
Learning Outcome: 30.5. Summarize the development of spirituality across the lifespan.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

14) The nurse is providing care to a client who has just received a diagnosis of cancer. Which findings would suggest that the client is experiencing spiritual distress? **Select all that apply.**
A) Client is observed crying with children.
B) Client tells the nurse about feeling hopeless.
C) Client discusses possible outcomes with healthcare provider.
D) Client turns off a religious show on the TV and stares out the window.
E) Client is talking quietly with spouse.
Answer: B, D
Explanation: A) Crying with children is a normal response to a cancer diagnosis.
B) Telling the nurse about feeling hopeless indicates spiritual distress.
C) Discussing possible outcomes is a normal response to a cancer diagnosis.
D) Turning off a religious TV show indicates spiritual distress.
E) Talking quietly with the spouse is a normal response to a cancer diagnosis.
Page Ref: 2068-2069
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 30.1. Distinguish between spiritual wellness and spiritual discomfort.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

15) The nurse is caring for a client who was recently diagnosed with a terminal illness. Which statement made by the client would indicate to the nurse that the client is in spiritual distress?
A) "I am not sure why this is happening, but I believe God has a plan for me."
B) "I wish I did not have cancer, but I believe that it is happening for a reason."
C) "My children don't go to church, and they are having a difficult time dealing with my diagnosis."
D) "People tell me things happen for a reason, but why is God doing this to me?"
Answer: D
Explanation: A) This answer does not indicate spiritual distress of the client.
B) This answer does not indicate spiritual distress of the client.
C) This answer does not indicate spiritual distress of the client.
D) The statement "But why is God doing this to me?" is reflective of spiritual distress. The client is not demonstrating being able to find a purpose and is also demonstrating a disconnect between herself and her higher spirit.
Page Ref: 2067-2068
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 30.1. Distinguish between spiritual wellness and spiritual discomfort.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

16) The nurse enters a client's room to assess why the alarm on an IV infusion has sounded. As the nurse checks the IV equipment, the client says he would like someone to pray with. How should the nurse address the client's spiritual needs while providing necessary IV care?
A) The nurse should focus her attention solely on the infusion, because it is more important at this time than the client's prayer request.
B) The nurse should nod in response to the client's request while taking care of the infusion.
C) While taking care of the infusion, the nurse should offer to call a clergy member.
D) After assessing that the alarm is not an emergency, the nurse should offer to pray with the client.
Answer: D
Explanation: A) Focusing on the IV does not indicate that the nurse is fully present with the client.
B) The nurse should not ignore the client's request.
C) The client did not ask for a clergy member.
D) The nurse can best address this client's spiritual needs by being fully present with the patient and not being distracted by other tasks such as assessing the IV infusion. Although the nurse's first priority is to assess that the alarm is not an emergency, she can then stop and be fully present by listening to the client's request and offering to pray with the client.
Page Ref: 2071
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Implementation
Learning Outcome: 30.6. Analyze the nurse's role in supporting the spiritual health of patients.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

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17) The nurse is performing a holistic assessment of a client. Which observations indicate that the client is experiencing spiritual distress? **Select all that apply.**
A) The client is sitting in a chair before breakfast reading the Bible.
B) The client states he has lost his faith in God since he's gotten ill.
C) The client is watching a religious program on the television.
D) The client is crying, pacing, and mumbling about God being angry with him.
E) The client is overheard arguing with clergy about the existence of God.
Answer: B, D, E
Explanation: A) The client who is observed sitting in a chair before breakfast reading the Bible is demonstrating a behavior of spiritual health.
B) The client who states a loss of faith in God after getting ill may be experiencing spiritual distress.
C) The client who is watching a religious program on the television is demonstrating a behavior of spiritual health.
D) The client who is crying, pacing, and mumbling about God being angry with him, may be experiencing spiritual distress.
E) The client who is overheard arguing with clergy about the existence of God may be experiencing spiritual distress.
Page Ref: 2067-2068
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 30.1. Distinguish between spiritual wellness and spiritual discomfort.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

18) The nurse is caring for a client in spiritual distress. The client has met with the hospital chaplain but did not find it beneficial. The nurse recognizes that outside assistance from the client's own spiritual advisor may be helpful. Which action should the nurse take before making an appointment with the advisor?

A) Consult with the primary care provider to find an available counselor.
B) Ask the client's permission to contact the counselor.
C) Call the hospital chaplain to come speak with the client.
D) Advocate with the primary care provider to offer spiritual care to the client.

Answer: B

Explanation: A) The nurse does not need to consult with the primary care provider to find an available counselor.

B) The client's permission is needed before seeking an outside counselor in order to protect the client's right to confidentiality. Therefore, the nurse should ask the client's permission before contacting the counselor.

C) Although the nurse could call the hospital chaplain to come speak with the client, this is not required before scheduling an appointment with an outside counselor.

D) The nurse should not ask the primary care provider to offer spiritual care to the client.

Page Ref: 2071

Cognitive Level: Understanding

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Implementation

Learning Outcome: 30.6. Analyze the nurse's role in supporting the spiritual health of patients.

MNL LO: Analyze the concept of spirituality and its application to nursing care.

19) While helping a client with the evening meal, the nurse observes the client close the eyes, bow the head, and murmur words of thanks and praise. In which way should the nurse interpret this behavior?
A) The client did not want the nurse to leave.
B) The client was asking that the meal be better than the last.
C) The client is confused.
D) The client was praying before eating.
Answer: D
Explanation: A) The client was not delaying the nurse so that she did not leave.
B) The nurse has no way of knowing if the client was asking that the meal be better than the last.
C) The client was not demonstrating confusion.
D) The client's behavior of bowing the head, closing the eyes, and murmuring words of thanks and praise are indications that the client was praying.
Page Ref: 2079
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 30.2. Discuss how religious practices may impact nursing and health care.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

20) A client requests that surgery be delayed for several days until after a period of Holy Days has concluded. Which action by the nurse supports this client's request?
A) Remind the client that one's health is more important than following Holy Days.
B) Provide the client with alternative forms of treatment to replace having surgery.
C) Suggest the client think about whether having the surgery is the right decision, as the client is willing to delay it now.
D) Communicate the client's request to the surgeon.
Answer: D
Explanation: A) The nurse should not remind the client that health is more important than following Holy Days.
B) The nurse should not provide the client with alternative forms of treatment to replace having surgery, as this is outside the nurse's scope of practice.
C) The nurse should not suggest that the client consider not having surgery.
D) To support the client's need to avoid surgery during Holy Days, the nurse should communicate the client's request to the surgeon.
Page Ref: 2069
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Implementation
Learning Outcome: 30.2. Discuss how religious practices may impact nursing and health care.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

21) A client who is scheduled for surgery wants to continue to wear a religious medallion. Which actions by the nurse support the client's religious needs? **Select all that apply.**
A) Keep the medallion on the client but remove it once anesthesia is provided.
B) Ask the client if wearing a medallion is going to ensure a successful surgery.
C) Document that the medallion is being worn by the client.
D) Suggest the client not wear the medallion because it will most likely be lost.
E) Explain that the medallion can be safety pinned to the client's gown.
Answer: C, E
Explanation: A) The nurse should not remove the medallion after anesthesia is provided.
B) The nurse should not confront the client by asking if the medallion is going to ensure successful surgery.
C) The nurse should document that the medallion is being worn by the client.
D) The nurse should not tell the client that the medallion will be lost if worn.
E) The nurse should explain that the medallion can be safety pinned to the client's gown. This approach would ensure compliance with the client's religious needs as well as safety for any surgical intervention planned for the client.
Page Ref: 2070
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Implementation
Learning Outcome: 30.2. Discuss how religious practices may impact nursing and health care.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

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22) A client is abstaining from meat and dairy products during Lent and refuses to select these items when making meal choices. Which actions by the nurse support the client's nutritional and religious needs? **Select all that apply.**

A) Ask the healthcare provider to discuss the impact of the restricted diet on the client's health.
B) Provide soy milk products as supplements.
C) Add protein powder supplements to the client's water pitcher.
D) Ask the client what foods are typically consumed during this period of time.
E) Consult with a dietitian for food choices to meet the client's needs.

Answer: D, E

Explanation: A) The nurse should not ask the physician to talk about the restricted diet with the client.

B) The nurse should not provide soy milk products as supplements because the client may not like them.

C) The nurse should not provide protein powder supplements in the client's water pitcher.

D) The nurse should ask the client what foods are typically consumed during this period of time.

E) The best interventions would be for the nurse to consult with a dietitian for food choices to meet the client's health and religious needs.

Page Ref: 2075
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Implementation
Learning Outcome: 30.2. Discuss how religious practices may impact nursing and health care.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

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23) The nurse is preparing to discharge a client from the hospital. Which actions by the client indicate that religious needs were met during the hospitalization? **Select all that apply.**
A) Requesting and attending religious services in the hospital chapel
B) Thanking the nurse for contacting a priest to visit while hospitalized
C) Asking nurse for additional supplies to change dressings while at home
D) Refusing home care services because the client's daughter is a nurse and a Sunday school teacher
E) Asking the nurse whom to call if problems occur after surgery
Answer: A, B
Explanation: A) Evidence that a client's religious needs were met while hospitalized would be the client requesting and attending religious services in the hospital chapel.
B) Evidence that a client's religious needs were met while hospitalized would be the client thanking the nurse for contacting the priest.
C) Asking for additional supplies to change dressings at home is unrelated to spiritual care.
D) Telling the nurse that home care is not needed is unrelated to spiritual care.
E) Asking whom to call for problems at home is unrelated to spiritual care.
Page Ref: 2079
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Evaluation
Learning Outcome: 30.2. Discuss how religious practices may impact nursing and health care.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

24) The nurse is developing a plan of care for a devout Muslim client. Which intervention should the nurse anticipate being a priority for this client?
A) The client will be able to participate in observing Sabbath.
B) The client will be able to participate in daily prayer with a rosary.
C) The client will be able to participate in reading the Torah.
D) The client will be able to participate in prayer at specific times without interruption.
Answer: D
Explanation: A) Observing the Sabbath is common to Christianity and Judaism.
B) Daily prayer with a rosary is common to Catholicism.
C) Reading the Torah is specific to Judaism.
D) Nurses working with Muslim clients should be aware that many Muslims pray five times a day, and when developing the plan of care, they should take prayer times into consideration if this is important to the client.
Page Ref: 2073
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Planning
Learning Outcome: 30.2. Discuss how religious practices may impact nursing and health care.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

25) The nurse is providing care to several clients. Which clients are most likely to request a vegetarian diet due to religious beliefs? **Select all that apply.**
A) A Catholic client
B) A Jewish client
C) A Hindu client
D) An Episcopalian client
E) A Seventh-Day Adventist client
Answer: C, E
Explanation: A) A Catholic client may opt to abstain from certain types of food but is not likely to be vegetarian because of religious beliefs.
B) A Jewish client may opt to abstain from certain types of food but is not likely to be vegetarian because of religious beliefs.
C) Of the individuals listed, the Hindu client is most likely to be vegetarian because of religious beliefs.
D) An Episcopalian client may observe some degree of abstention from food but is not likely to be vegetarian because of religious beliefs.
E) Of the individuals listed, the Seventh-Day Adventist client is most likely to be vegetarian because of religious beliefs.
Page Ref: 2072
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Planning
Learning Outcome: 30.2. Discuss how religious practices may impact nursing and health care.
MNL LO: Analyze the concept of spirituality and its application to nursing care.

26) The nurse is providing care to a Catholic client who describes herself as "extremely devout." Which treatment option is most likely to cause spiritual distress for this client?
A) Blood transfusion for anemia
B) Specialized cardiac diet
C) Elective termination of pregnancy
D) A below-the-knee amputation
Answer: C
Explanation: A) Blood transfusions are less likely to cause this client spiritual distress because it is not prohibited by Catholic teaching.
B) A specialized cardiac diet is less likely to cause this client spiritual distress because it is not prohibited by Catholic teaching.
C) Elective termination of pregnancy, or abortion, is the treatment most likely to cause a devout Catholic client spiritual distress.
D) Below-the-knee amputation is less likely to cause this client spiritual distress because it is not prohibited by Catholic teaching.
Page Ref: 2072
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 30.2. Discuss how religious practices may impact nursing and health care.

MNL LO: Analyze the concept of spirituality and its application to nursing care.

27) The nurse is caring for a client who is actively engaged in an organized religion. Based on this statement, the nurse knows that which statement is most likely true?

A) The client believes in the presence of only one god.

B) The client knows other individuals from the same religion who may be available to offer emotional and spiritual support.

C) The client lives by the moral code of the Ten Commandments.

D) The client will require time set aside for prayer several times each day, and the nurse will need to work around this schedule.

Answer: B

Explanation: A) Without knowing the client's specific religion, the nurse cannot assume that the client believes in the presence of only one god.

B) Individuals who are actively engaged in a specific religion are usually part of a religious community. Members of this community are often called upon for emotional and spiritual support, especially during times of hardship or illness.

C) Without knowing the client's specific religion, the nurse cannot assume that the client lives by the moral code of the Ten Commandments.

D) Without knowing the client's specific religion, the nurse cannot assume that the client will need to set aside specific times each day for prayer.

Page Ref: 2074

Cognitive Level: Understanding

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; Accept and respond to distress in patient and self; Facilitate hope, trust, and faith. | Nursing Process: Assessment

Learning Outcome: 30.2. Discuss how religious practices may impact nursing and health care.

MNL LO: Analyze the concept of spirituality and its application to nursing care.

***Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e* (Pearson)**

Module 31 Stress and Coping

The Concept of Stress and Coping

1) After a mammogram, a client is told that she needs a fine needle aspirate of a breast mass. Which action by the client demonstrates engagement in a primary appraisal of the stressful situation?
A) Holding her breath while the nurse is talking
B) Sitting in the dressing room crying
C) Asking the nurse if she has cancer
D) Scheduling the procedure in 6 weeks, which is the earliest possible appointment
Answer: C
Explanation: A) The client holding her breath while the nurse is talking is evaluating coping resources and options. This is a secondary appraisal.
B) The client who sits in the dressing room and cries is applying a coping resource. This is coping.
C) In primary appraisal, the client assesses the potential for benefit, harm, loss, threat, or challenge in a situation. The client asking the nurse if she has cancer is engaging in a primary appraisal.
D) The client who schedules the procedure at the earliest possible appointment is engaging in reappraisal, which is an ongoing reinterpretation of the situation based on new information.
Page Ref: 2087
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 31.2. Explain types of stressors and the psychodynamics of coping.
MNL LO: Analyze the concept of stress and coping and its application to nursing care.

2) A client states to the nurse that learning how to use the blood glucose machine will have to wait until holiday events are planned. Which cognitive indication of stress is the client demonstrating?
A) Problem solving
B) Suppression
C) Self-control
D) Cognitive structuring
Answer: B
Explanation: A) Problem solving involves thinking through a challenging situation, using specific steps to arrive at a solution.
B) The client is demonstrating suppression, which is the conscious process of denying unacceptable thoughts or emotions. The client is focusing on other needs and not the need to learn how to use the blood glucose machine.
C) Self-control is the ability to restrain oneself from acting on impulse or to act in such a way as to delay gratification.
D) Cognitive structuring uses mental processes to make sense of environmental stimuli.
Page Ref: 2054, 2092
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 31.3. Outline the manifestations and indicators of stress.
MNL LO: Analyze the concept of stress and coping and its application to nursing care.

3) A client worries every day about personal health and states, "I may not have enough medication if the weather takes a turn for the worse." This client is exhibiting a sign of which alteration in stress and coping?

A) Generalized anxiety disorder
B) Phobia
C) Obsessive-compulsive disorder
D) Panic disorder

Answer: A

Explanation: A) Generalized anxiety disorder is excessive worry about everyday problems, with the anxiety being more intense than the situation warrants. The client is demonstrating signs of generalized anxiety disorder.

B) A phobia is an intense, persistent, irrational fear of a simple thing or social situation that compels the individual to avoid the stressor that elicits the fear.

C) Obsessive-compulsive disorder is characterized by obsessive thoughts and compulsive repetitive behaviors formed in response to the obsessive thoughts to lower the level of anxiety experienced.

D) Panic disorder is a sudden attack of terror, accompanied by a pounding heart, sweatiness, weakness, faintness, or dizziness.

Page Ref: 2096
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 31.5. Differentiate alterations in coping.
MNL LO: Analyze the concept of stress and coping and its application to nursing care.

4) Which assessment findings indicate to the nurse that a client is experiencing stress? **Select all that apply.**
A) Chewing on a fingernail
B) Checking the smart phone
C) Reading a magazine
D) Talking with others
E) Tapping foot
Answer: A, E
Explanation: A) Nail biting is a behavior indicator of stress.
B) Checking the smart phone is not an indication of stress.
C) Reading a magazine is not an indication of stress.
D) Talking with others is not an indication of stress.
E) Foot tapping is a physical indication of stress.
Page Ref: 2099
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 31.7. Differentiate among common assessment procedures and tests used to examine levels of stress and coping mechanisms.
MNL LO: Analyze the concept of stress and coping and its application to nursing care.

5) A client complains about the stress of having to work long hours and missing daily exercise routines. Which response by the nurse is appropriate?
A) "There are other ways to reduce stress, such as meditation."
B) "Exercise helps reduce the impact of stress on the body and would be a good thing."
C) "Drinking a small glass of wine each day does help reduce stress."
D) "Maybe exercising, with all of the work, would be too much for your body anyway."
Answer: B
Explanation: A) Meditation might be beneficial, but because the client mentioned initially exercising and not meditating, this suggestion is not as appropriate in addressing the client's needs.
B) The client had been exercising but has not been recently because of additional work, which is causing stress. The nurse should encourage the client to resume daily exercise to reduce the impact of the stress on the body.
C) The nurse should not suggest using alcohol to deal with stress.
D) The nurse should not reinforce the client's not exercising.
Page Ref: 2098
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Implementation

Learning Outcome: 31.6. Explain the promotion of healthy coping and the prevention of stress-related illness.
MNL LO: Analyze the concept of stress and coping and its application to nursing care.

6) Which intervention would help a client who is stressed about being hospitalized because of the needs of children at home?
A) Ask the client if there is anything that is needed once discharged to home.
B) Ask the client if there is anyone who would be able to help with the family needs at home during recuperation.
C) Find out if the children can be sent to a grandparent's home until the client fully recovers.
D) Suggest the client be transferred to a long-term care facility to ensure a full recovery.
Answer: B
Explanation: A) Asking the client if there is anything that is needed once discharged is not enough. The nurse needs to do something else.
B) The nurse needs to focus on what can be done right away to help the client. The best way that the nurse can help this client is to ask if there is anyone who can help the client at home.
C) Sending the children to a grandparent's home might not work if the children are in school and the grandparent lives far away.
D) Transferring the client to a long-term care facility will not help the client with the stress of caring for a family at home.
Page Ref: 2092
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Implementation
Learning Outcome: 31.7. Differentiate among common assessment procedures and tests used to examine levels of stress and coping mechanisms.
MNL LO: Analyze the concept of stress and coping and its application to nursing care.

7) Which instruction by the nurse to a client prescribed diazepam (Valium) for anxiety and stress is appropriate?
A) "This medication will be good to take for a long time."
B) "Take this medication every time feelings of stress become overwhelming."
C) "This medication works best if taken with a meal."
D) "This medication is good to use for the short term only."
Answer: D
Explanation: A) Diazepam (Valium) may be effective in quickly lowering the severity of a client's anxiety but is generally not recommended for use beyond a few weeks because of its addictive properties.
B) Instructing the client to take the medication every time feelings of stress become overwhelming could lead to an overdose and should not be done.
C) There is no indication that this medication needs to be taken with a meal.
D) Diazepam (Valium) is a benzodiazepine that is typically used for short-term treatment during an acute phase of an anxiety disorder.
Page Ref: 2100
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Integration of knowledge from nursing and other disciplines. | Nursing Process: Implementation
Learning Outcome: 31.9. Summarize collaborative therapies used by interprofessional teams for patients with stress-related illness and alterations in coping.
MNL LO: Analyze the concept of stress and coping and its application to nursing care.

8) The nurse on the behavioral health unit is caring for a client diagnosed with depression who just lost a spouse in a motor vehicle crash. The client states to the nurse, "My wife would not have wanted to live if she were disabled." Based on this statement, which defense mechanism is the client using?
A) Identification
B) Denial
C) Intellectualization
D) Displacement
Answer: C
Explanation: A) Identification is an attempt to manage anxiety by imitating the behavior of someone feared or respected.
B) Denial is an attempt to screen or ignore unacceptable realities by refusing to acknowledge them.
C) Intellectualization is a mechanism by which an emotional response that normally would accompany an uncomfortable or painful incident is evaded by the use of rational explanations that remove from the incident any personal significance and feelings.
D) Displacement is the transferring or discharging of emotional reactions from one object or individual to another object or individual.
Page Ref: 2093
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 31.3. Outline the manifestations and indicators of stress.
MNL LO: Analyze the concept of stress and coping and its application to nursing care.

9) Which hormone is one of the primary mediators of stress?
A) Glucagon
B) Cortisol
C) Serotonin
D) Somatostatin
Answer: B
Explanation: A) Glucagon is secreted by the pancreas to increase blood glucose levels.
B) The two primary stress mediators are glucocorticoids (e.g., cortisol) and catecholamines (e.g., epinephrine).
C) Serotonin is a neurotransmitter that is involved in some mood and anxiety disorders, but it is not a primary mediator of stress.
D) Somatostatin is a hormone released by the pituitary gland. It is not involved in the stress response.
Page Ref: 2048, 2084
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 31.1. Contrast stress and homeostasis.
MNL LO: Analyze the concept of stress and coping and its application to nursing care.

10) Occupation-specific stressors that are ongoing and unmanaged can lead to which extreme form of stress?

A) Distress
B) Eustress
C) Allostasis
D) Burnout

Answer: D

Explanation: A) Distress is bad stress that is associated with inadequacy, insecurity, and loss. Although occupation-specific stressors can be a type of distress, distress is not the specific term for the extreme form of stress caused by ongoing and unmanaged stress.

B) Eustress is good stress that leads to accomplishment and victory.

C) Allostasis refers to the changes necessary to achieve homeostasis.

D) Although occupation-specific stressors can be a type of distress, distress is not the specific term for the extreme form of stress caused by ongoing and unmanaged stress. The term used for that form of extreme stress is burnout. Burnout in nurses can lead to reduced quality of care and decreased patient satisfaction.

Page Ref: 2094
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.C.2. Appreciate the cognitive and physical limits of human performance. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Appreciate the cognitive and physical limits of human performance. | Nursing Process: Assessment
Learning Outcome: 31.4. Outline the relationship between stress and coping and other concepts.
MNL LO: Analyze the concept of stress and coping and its application to nursing care.

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11) Which intervention can the nurse implement independently when caring for a client with alterations in stress and coping?
A) Therapeutic communication
B) Cognitive-behavioral therapy
C) Psychotherapy
D) Administration of medications
Answer: A
Explanation: A) Using therapeutic communication is an essential intervention that the nurse can implement independently when caring for a client with an alteration in stress and coping.
B) Cognitive-behavioral therapy is a collaborative intervention.
C) Psychotherapy is a collaborative intervention.
D) Administration of medications is a collaborative intervention.
Page Ref: 2100
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.9. Discuss principles of effective communication. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Communicate information effectively; listen openly and cooperatively. | Nursing Process: Implementation
Learning Outcome: 31.8. Analyze independent interventions nurses can implement for patients with alterations in stress and coping.
MNL LO: Analyze the concept of stress and coping and its application to nursing care.

12) Which child would the nurse recognize as being at the highest risk of experiencing toxic stress?

A) A 15-year-old adolescent who is slightly overweight and didn't make the football team; he regularly gets teased for his weight at school.

B) A 2-week-old infant who was born at 31 weeks' gestation and has been in the neonatal intensive care unit (NICU) for the entire 2 weeks; the child's parents are at the hospital as often as possible.

C) A 12-year-old child whose father recently died and whose mother works three part-time jobs; this child is expected to care for two younger siblings after school.

D) A 4-year-old child who attends preschool or daycare each day while the parents work; the child displays signs of mild separation anxiety.

Answer: C

Explanation: A) The 15-year-old adolescent is experiencing normative stressors, which do not usually lead to toxic stress.

B) The 2-week-old infant may be experiencing non-normative stress, but the infant is receiving appropriate adult support and is likely too young to be cognitively aware of stressors.

C) The 12-year-old child has experienced a non-normative stressor in the death of the father, and the child does not have adequate adult support. This places the child at high risk for toxic stress.

D) The 4-year-old child is experiencing normative stressors, which do not usually lead to toxic stress.

Page Ref: 2102

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: The role of family, culture, and community in a person's development. | Nursing Process: Assessment

Learning Outcome: 31.10. Differentiate considerations related to the care of patients with stress throughout the lifespan.

MNL LO: Analyze the concept of stress and coping and its application to nursing care.

13) The nurse is assessing a 68-year-old client who appears disheveled. At previous appointments, the client was well kept with good hygiene practices. Today, the client's clothes do not match, the client's hair is unkempt, and the client has intense body odor. The nurse is concerned about this change in self-care. When conducting the assessment, which primary factor should the nurse consider?

A) Whether the changes are due to a lack of understanding of technology
B) Whether the changes are due to stress or dementia
C) Whether the client is taking all medications as prescribed
D) Whether the client is living independently

Answer: B

Explanation: A) A lack of understanding of technology could cause stress which would be a secondary consideration after determining whether the changes are due to stress or dementia.

B) In older clients, changes in self-care habits are frequently in response to stress, but they could also be related to dementia and an inability to remember how to use basic grooming tools. The nurse needs to determine the cause of the self-care changes.

C) Forgetting to take medications could be a sign of dementia which would be a secondary consideration after determining whether the changes are due to stress or dementia.

D) Living independently could be a cause of stress and would be a secondary consideration after determining whether the changes are due to stress or dementia.

Page Ref: 2104
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of the human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment

Learning Outcome: 31.10. Differentiate considerations related to the care of patients with stress throughout the lifespan.
MNL LO: Analyze the concept of stress and coping and its application to nursing care.

Exemplar 31.A Anxiety Disorders

1) A client, who is experiencing anxiety, is trembling and complaining of dizziness and palpitations. The client is having a hard time following the nurse's instructions. Based on this data, which level of anxiety is the client likely experiencing?
A) Panic
B) Severe
C) Moderate
D) Mild
Answer: B
Explanation: A) Panic is associated with dilated pupils, pallor, diaphoresis, and bizarre behavior.
B) Severe anxiety can be associated with trembling, dizziness, palpitations, and difficulty following directions, among other signs and symptoms.
C) Moderate anxiety results in a reduction in awareness and increased restlessness and irritability.
D) Mild anxiety causes an increase in alertness and sensory perception.
Page Ref: 2110
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Identify the clinical manifestations of anxiety disorders.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

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2) A client, who was recently laid off from work, is scheduled for a biopsy to evaluate a site for malignancy. When planning this client's care, which does the nurse include?
A) Reasons to delay the biopsy
B) Medicate around the clock for pain
C) Interventions to address anxiety
D) Social services to aid with financial planning
Answer: C
Explanation: A) Delaying the biopsy will not help reduce anxiety.
B) There is no evidence to suggest the client is experiencing pain.
C) Risk factors for anxiety disorders include multiple stressors such as an illness occurring with a change in employment. The nurse should plan interventions to address anxiety.
D) Social services may or may not be needed for the client's financial planning.
Page Ref: 2107
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Planning
Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Compare the risk factors for and prevention of anxiety disorders.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

3) The nurse is evaluating medication teaching for a client who recently started taking fluoxetine (Prozac) for anxiety. Which statement by the client indicates appropriate understanding of the information presented?
A) "My medication will take 1 week to become effective."
B) "My medication will take 4 weeks to become effective."
C) "My medication will become effective immediately after I start taking it."
D) "My medication will not begin to work for 12 weeks."
Answer: B
Explanation: A) It will take longer than 1 week for fluoxetine (Prozac) to be effective.
B) Fluoxetine (Prozac) is a selective serotonin reuptake inhibitor (SSRI). Although these drugs begin to alter brain chemistry after the first dose, their full effect requires a few weeks because a series of neurobiological changes must take place before SSRIs achieve efficacy.
C) Fluoxetine (Prozac) will not become effective immediately after taking it. Although these drugs begin to alter brain chemistry after the first dose, their full effect requires a few weeks because a series of neurobiological changes must take place before SSRIs achieve efficacy.
D) Fluoxetine (Prozac) will become effective after 4 weeks and not 12 weeks.
Page Ref: 2111
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Evaluation
Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of individuals with anxiety disorders.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

4) The nurse is instructing a client with an anxiety disorder on behavioral tools to help with coping. Which tools to help with coping should the nurse include in the teaching session? **Select all that apply.**
A) Relaxation techniques
B) Thought stopping
C) Journaling
D) Distraction
E) Practicing yoga
Answer: A, C, D, E
Explanation: A) Behavioral tools to help with coping include relaxation techniques.
B) Thought stopping is a cognitive coping tool.
C) Behavioral tools to help with coping include journaling stressors and emotional responses and alternatives.
D) Behavioral tools to help with coping include distraction.
E) Behavioral tools to help with coping include yoga.
Page Ref: 2109-2110
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Implementation

Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of individuals with anxiety disorders.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

5) Which is the priority nursing action when providing care to a client who demonstrates signs of escalating anxiety?
A) Isolate the client in a safe, quiet, and protective environment.
B) Leave the client alone in a room.
C) Provide a benzodiazepine.
D) Phone the physician.
Answer: A
Explanation: A) The nurse should first isolate the severely anxious or panicked client in a safe, quiet, protective environment.
B) The nurse should not leave the client unattended.
C) Medications can be provided once the client is in a safe, protective environment.
D) Phoning the physician may not be helpful to the client.
Page Ref: 2110
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Implementation
Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Apply the nursing process in providing culturally competent care to an individual with an anxiety disorder.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

6) The nurse is admitting a client experiencing a panic attack to the behavioral health unit. Which clinical manifestations would indicate that the client's anxiety is at a panic level of severity? **Select all that apply.**

A) Inability to focus
B) Dilated pupils
C) Feelings of doom
D) Self-absorption
E) Rapid speech
Answer: A, B, C
Explanation: A) An inability to focus is a clinical manifestation that the client's anxiety is at the panic level of severity.
B) Dilated pupils are a clinical manifestation that the client's anxiety is at the panic level of severity.
C) Feelings of doom are a clinical manifestation that the client's anxiety is at the panic level of severity.
D) Self-absorption is a clinical manifestation that the client's anxiety is at a moderate level of severity.
E) Rapid speech is a clinical manifestation that the client's anxiety is at a moderate level of severity.
Page Ref: 2110
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Identify the clinical manifestations of anxiety disorders.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

7) The nurse is leading a group regarding risk factors for anxiety. At the completion of group work, which comment made by a client would indicate the need for further teaching?
A) "A lack of social interaction places me at risk for anxiety."
B) "My personality could place me at risk for anxiety because I am shy."
C) "Chronic illness is not a risk factor unless I am also unemployed."
D) "I experienced a traumatic event that placed me at risk for having this anxiety disorder."
Answer: C
Explanation: A) Lack of social interaction is a risk factor for anxiety.
B) Personality factors such as shyness is a risk factor for anxiety.
C) Chronic illness is a risk factor for anxiety disorders with or without the unemployment factor.
D) Traumatic events are risk factors for anxiety.
Page Ref: 2107
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Compare the risk factors for and prevention of anxiety disorders.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

8) A client diagnosed with general anxiety disorder (GAD) is prescribed a selective serotonin reuptake inhibitor (SSRI). Which statement indicates to the nurse the client needs additional information about the medication?

A) "This medicine could make me feel agitated."
B) "I may experience some nausea while on this medication."
C) "My doctor will start me off on a high dose and then decrease the dose."
D) "This medicine alters the levels of the neurotransmitter serotonin in the brain."

Answer: C

Explanation: A) A side effect of SSRIs is agitation.
B) A side effect of SSRIs is nausea.
C) SSRIs are generally started at low doses and then increased as their effectiveness becomes apparent.
D) SSRIs alter the level of the neurotransmitter serotonin in the brain.

Page Ref: 2111

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of individuals with anxiety disorders.

MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

9) A client states, "I haven't left my house for 6 years." Based on this data, for which condition should the nurse anticipate planning care for this client?
A) Panic disorder
B) Social anxiety disorder
C) Moderate anxiety
D) Agoraphobia
Answer: D
Explanation: A) The client is not demonstrating any signs of panic.
B) Social anxiety disorder is a fear of one or more social situations that may lead to scrutiny by others.
C) The client is not demonstrating signs of moderate anxiety.
D) Agoraphobia is characterized by anxiety associated with two or more of the following situations: being in enclosed spaces, being in open spaces, using public transportation, being in a crowd or standing in a line of people, or being alone outside the home environment.
Page Ref: 2109
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Planning
Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Identify the clinical manifestations of anxiety disorders.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

10) A client states to the nurse, "I experience shortness of breath and dizziness every time I get into an elevator." Which actions by the nurse are appropriate based on this data? **Select all that apply.**

A) Assist the client to rethink the degree of anxiety associated with elevators.

B) Ask the client how they have survived in life so far with elevators.

C) Instruct the client in deep breathing exercises.

D) Suggest that the client should avoid elevators.

E) Tell the client that elevators are completely safe.

Answer: A, C

Explanation: A) Assisting the client to rethink the degree of anxiety associated with elevators helps clients recognize and change the thought patterns that support their fears, and the behavioral aspect helps clients change the way they react to anxiety-provoking situations. This is a technique used in cognitive-behavioral therapy.

B) Asking the client how they have survived in life so far with elevators will not help the situation.

C) Deep breathing exercises can help the client reduce the anxiety associated with a fearful situation, such as entering an elevator.

D) Suggesting that the client avoid elevators will not help the client.

E) Telling the client that elevators are completely safe might not be true and should not be said to the client.

Page Ref: 2111-2112

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Implementation

Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Apply the nursing process in providing culturally competent care to an individual with an anxiety disorder.

MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

11) Free-floating anxiety is often connected to which stimulus?
A) Elevators
B) Airplanes
C) No specific stimulus
D) Water
Answer: C
Explanation: A) Anxiety caused by elevators is linked to a specific stimulus.
B) Anxiety caused by airplanes is linked to a specific stimulus.
C) Free-floating anxiety is characterized by excessive worry that is hard to control and whose focus may shift from moment to moment. Free-floating anxiety is anxiety that is not connected to a specific stimulus.
D) Anxiety caused by water is linked to a specific stimulus.
Page Ref: 2105
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Describe the pathophysiology of anxiety disorders.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

12) A client wants to be tested for an anxiety disorder because a parent and sibling have the disorder. Which theory related to the etiology of anxiety disorders is this client demonstrating?
A) Neurochemical
B) Neurobiological
C) Genetic
D) Humanistic
Answer: C
Explanation: A) Neurochemical theories state that anxiety disorders are related to a disruption in neurotransmitter regulation.
B) Neurobiological theories state that anxiety disorders are related to specific areas of the brain.
C) Genetic theories state that genetic predisposition plays a part in the development of anxiety disorders, with first-order family members being at higher risk of developing an anxiety disorder.
D) Humanistic theories state that multiple factors contribute to the development of anxiety disorders.
Page Ref: 2107
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Describe the etiology of anxiety disorders.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

13) A client at which levels of anxiety would be most receptive to learning tools that would help the client recognize triggers? **Select all that apply.**
A) Mild
B) Moderate
C) Severe
D) Panic
E) Phobia
Answer: B, C
Explanation: A) Mild anxiety is typically resolved by an individual's coping mechanisms. Mild anxiety may be helpful to the client to accentuate focus and concentration.
B) Clients with moderate anxiety would be able to learn about how to recognize triggers.
C) Clients with severe anxiety would be able to learn about how to recognize triggers.
D) Clients experiencing panic are not able to learn new tools and would first need other interventions to help reduce their level of anxiety before they could learn how to recognize triggers for anxiety.
E) Phobia is not a level of anxiety.
Page Ref: 2109-2110
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Communicate information effectively; listen openly and cooperatively. | Nursing Process: Implementation

Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Apply the nursing process in providing culturally competent care to an individual with an anxiety disorder.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

14) A client taking antianxiety medication wants to become pregnant but is concerned that the medication will harm the developing fetus. Which response should the nurse make about antianxiety medication during pregnancy?
A) Antianxiety medication is not harmful to the fetus.
B) Consider switching to cognitive-behavioral therapy (CBT) rather than medication.
C) Stop all medications immediately.
D) Gradually decrease medication until pregnancy occurs.
Answer: B
Explanation: A) Depending upon the category of medication, antianxiety medication can cause fetal respiratory disorders and fetal difficulties.
B) For clients desiring to become pregnant, nonpharmacologic therapies such as CBT and relaxation techniques are the safest for reducing anxiety and preventing harm to the fetus.
C) The client should not stop all treatment immediately.
D) When stopping medication, the medication should be tapered off, but this should continue even after pregnancy occurs.
Page Ref: 2113
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Integration of knowledge from nursing and other disciplines. | Nursing Process: Implementation
Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Differentiate considerations for care of patients with anxiety disorders across the lifespan.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

15) An older adult experiencing restlessness, muscle tension, and increased perspiration states never being diagnosed with an anxiety disorder. Which situation should the nurse consider is causing the client's symptoms?
A) A medical illness
B) An overdose of medications
C) A change in the client's cognitive functioning
D) Drug-drug interactions between medications
Answer: A
Explanation: A) The scenario indicates that the client has not been previously diagnosed with an anxiety disorder, so the most likely explanation is that these symptoms are related to a medical illness other than anxiety, because manifestations of anxiety often overlap with manifestations of other medical illnesses in older adults.
B) There is no information provided about the client's current medications.
C) There is no evidence that the client has a change in cognitive functioning.
D) Because there is no information about the client's medications it is unlikely that the symptoms are being caused by drug-drug interactions.
Page Ref: 2113-2114
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 31.A. Analyze anxiety disorders as they relate to stress and coping. Differentiate considerations for care of patients with anxiety disorders across the lifespan.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with anxiety disorders.

Exemplar 31.B Crisis

1) The nurse is providing care to a client who is "in crisis." The client recently lost a job, was served with divorce papers, and has been sick with back-to-back colds for 1 month. Which nursing statement demonstrates understanding of the care of a client in crisis?
A) "Experiencing a crisis is never positive, so we must work to relieve your anxiety as soon as possible."
B) "People generally find it easier to work through a crisis if someone is working with them."
C) "Men often handle crisis better individually, whereas women do better with a counselor."
D) "Once you reach the crisis state, you may remain there for several months until you recover."
Answer: B
Explanation: A) Experiencing a crisis may actually offer the family or individual a potential for growth and change.
B) In general, people are more successful in working through a crisis if they have someone to help them.
C) The need for help is not gender dependent.
D) A crisis results in such a state of disequilibrium that it is generally self-limiting and not a long-term event.
Page Ref: 2121
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Communicate information effectively; listen openly and cooperatively. | Nursing Process: Assessment
Learning Outcome: 31.B. Analyze crisis as it relates to stress and coping. Apply the nursing process in providing culturally competent care to an individual in crisis.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient in crisis.

2) Which findings indicate to the nurse that an adolescent client graduating from high school is experiencing a maturational crisis? **Select all that apply.**

A) Relationship with significant other ended

B) Inability to focus on school studies

C) Cannot sleep at night and skips classes

D) Recent death of a friend

E) Graduating from high school in 2 months

Answer: B, C, E

Explanation: A) Having a relationship with a significant other end is a situational crisis.

B) Graduating from high school is a developmental progression to the next level of maturity, a predictable event experienced by nearly all individuals.

C) Inability to sleep and skipping classes are symptoms of a maturational crisis as the client is preparing to graduate from high school.

D) The recent death of a friend is a situational crisis.

E) Graduating from high school in 2 months is a maturational crisis.

Page Ref: 2119

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment

Learning Outcome: 31.B. Analyze crisis as it relates to stress and coping. Differentiate considerations for care of patients in crisis across the lifespan.

MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient in crisis.

3) Which problem would be a priority for a client who is experiencing a situational crisis?
A) Compromised coping skills
B) Risk of injury
C) Self-neglect
D) Confusion
Answer: A
Explanation: A) A situational crisis could lead to problems with the client’s usual coping methods.
B) There is minimal risk for injury in a situational crisis.
C) There is no evidence of self-neglect because of a situational crisis.
D) There is no evidence of confusion with a situational crisis.
Page Ref: 2126
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Diagnosis
Learning Outcome: 31.B. Analyze crisis as it relates to stress and coping. Apply the nursing process in providing culturally competent care to an individual in crisis.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient in crisis.

4) The nurse needs to plan interventions to address a client's crisis. Which action by the nurse is appropriate?

A) Develop the plan prior to meeting with the client.
B) Conduct a complete assessment.
C) Determine follow-up.
D) Focus on long-term problems.

Answer: B

Explanation: A) A plan cannot be developed prior to meeting with the client.
B) Nursing care is based on assessment.
C) The need for follow-up will be determined by the findings of the assessment.
D) The time frame, whether short term or long term will be determined by the findings of the assessment.

Page Ref: 2125
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 31.B. Analyze crisis as it relates to stress and coping. Apply the nursing process in providing culturally competent care to an individual in crisis.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient in crisis.

5) The nurse is beginning crisis counseling with a client. Which actions will the nurse use when counseling the client? **Select all that apply.**
A) Assist in coping with the problem.
B) Conduct follow-up assessments.
C) Boil down the problem.
D) Achieve rapport.
E) Assess physiologic status.
Answer: A, C, D
Explanation: A) When conducting crisis counseling with a client, the nurse will assist the client in coping with the problem.
B) Conducting follow-up assessments are not steps within crisis counseling.
C) When conducting crisis counseling with a client, the nurse will boil down the problem.
D) When conducting crisis counseling with a client, the nurse will achieve rapport.
E) Assessing physiologic status is not a step within crisis counseling.
Page Ref: 2123
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Current best practices | Nursing Process: Implementation
Learning Outcome: 31.B. Analyze crisis as it relates to stress and coping. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual in crisis.

MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient in crisis.

6) The nurse is caring for a client in crisis. Which criteria should the nurse follow when communicating with the client? **Select all that apply.**
A) Frequent
B) Brief
C) Simple
D) Detailed
E) Directive
Answer: A, B, C, E
Explanation: A) Communicating with individuals in crisis requires frequent communication.
B) Communicating with individuals in crisis requires brief communication.
C) Communicating with individuals in crisis requires simple communication.
D) Detailed communication would be contraindicated.
E) Communicating with individuals in crisis requires directive communication.
Page Ref: 2122
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.13. Assess own level of communication skill in encounters with patients and families. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Communicate information effectively; listen openly and cooperatively. | Nursing Process: Implementation
Learning Outcome: 31.B. Analyze crisis as it relates to stress and coping. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual in crisis.

MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient in crisis.

7) The nurse is assessing a client who is experiencing crisis. Which action is the priority for the nurse to take?
A) Scan for physical distress.
B) Explore perceptions of the crisis.
C) Develop a follow-up plan.
D) Assess for immediate safety needs.
Answer: D
Explanation: A) Scanning for physical distress does not take priority over safety.
B) Exploring perceptions of the crisis does not take priority over safety.
C) Developing a follow-up plan would occur only after other interventions have been implemented.
D) Assessing for immediate safety needs would take priority.
Page Ref: 2124
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment
Learning Outcome: 31.B. Analyze crisis as it relates to stress and coping. Apply the nursing process in providing culturally competent care to an individual in crisis.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient in crisis.

8) The nurse is providing care to a client who is experiencing a crisis. Which statement by the client indicates that the goals of care have yet to be met?
A) "I came up with some ideas on how to cope when I am in this position."
B) "I feel like I am in control and can begin managing things now."
C) "I am not sure whom I am going to call when I start feeling like this again."
D) "I can deal with this, I am a strong person, and I have a lot of friends and family."
Answer: C
Explanation: A) Identifying ideas for coping indicates goals have been met.
B) Feeling in control indicates goals have been met.
C) The client who is unsure of whom to call in a crisis has not met goals yet.
D) Having a strong support group indicates goals have been met.
Page Ref: 2128
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Quality and Safety: Contribute to assessment of outcome achievement. | Nursing Process: Evaluation
Learning Outcome: 31.B. Analyze crisis as it relates to stress and coping. Apply the nursing process in providing culturally competent care to an individual in crisis.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient in crisis.

9) Which phrase is an accurate description of a crisis?
A) An acute event that is detrimental
B) A chronic event that is intermittent
C) A chronic event that is consistent and ongoing
D) An acute event that will resolve
Answer: D
Explanation: A) A crisis is an acute event, but not all crises are detrimental.
B) A crisis is not a chronic event.
C) A crisis is not a chronic event that is consistent and ongoing.
D) A crisis is an acute event that usually resolves within 4-6 weeks.
Page Ref: 2119
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment
Learning Outcome: 31.B. Analyze crisis as it relates to stress and coping. Describe the characteristics of crisis.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient in crisis.

10) A client who has just experienced a crisis is likely to present to the emergency department with which clinical manifestation?
A) Depression
B) Disorientation
C) Fatigue
D) Sleeplessness
Answer: B
Explanation: A) Depression is a chronic condition that develops over time, not as the immediate result of a crisis.
B) Immediately after experiencing a crisis, the client is likely to present with disorientation.
C) The client likely will not yet be feeling fatigue immediately after the event.
D) The client likely will not yet be experiencing sleeplessness immediately after the event.
Page Ref: 2121
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 31.B. Analyze crisis as it relates to stress and coping. Identify the clinical manifestations of a crisis response.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient in crisis.

11) Which characteristic is essential for individuals to adapt to crisis in a positive way?
A) Security
B) Strength
C) Resilience
D) Independence
Answer: C
Explanation: A) Security is not essential for a person to adapt to crisis in a positive way.
B) Strength is not essential for a person to adapt to crisis in a positive way.
C) Resilience is the way in which individuals adapt successfully to crisis events to develop positive outcomes.
D) Independence is not essential for a person to adapt to crisis in a positive way.
Page Ref: 2119
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 31.B. Analyze crisis as it relates to stress and coping. Describe factors that affect individual response to crisis.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient in crisis.

12) The nurse is part of a disaster response team caring for individuals after a metro bus collided with a building. Which criteria must the nurse consider when assessing the emotional state of each individual?

A) The individual's previous healthcare experiences will make them more open to sharing emotions.

B) The individual's race or ethnicity will be a predictor of their resiliency.

C) The individual's emotional state is not as important as their physical injuries.

D) The individual's culture will influence their expression of emotions.

Answer: D

Explanation: A) Individuals who have had a negative experience with the healthcare system may be less open to sharing emotions.

B) Individuals of any race or ethnicity can display the characteristic of resilience during a crisis.

C) Although physical injuries may be more urgent, the person's physical and emotional state are both equally important and require nursing care.

D) Cultural factors may influence how an individual expresses emotions.

Page Ref: 2126

Cognitive Level: Understanding

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Communicate information effectively; listen openly and cooperatively. | Nursing Process: Assessment

Learning Outcome: 31.B. Analyze crisis as it relates to stress and coping. Identify the clinical manifestations of a crisis response.

WwW.TeSM.Ws

MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient in crisis.

13) A client who is pregnant learns that the baby will have a birth defect. Which response should the nurse make when the client begins to cry and voice concerns about paying for the baby’s care?
A) "If you calm down, we can talk about it. It's not as bad as it sounds."
B) "The first step is to learn more about what to expect. Let me help you."
C) "I know this is overwhelming, but everything will work out OK."
D) "Your love for your baby will outweigh all of the difficulties."
Answer: B
Explanation: A) Ignoring the client’s concerns or providing platitudes that may not be true are not effective ways to provide support to a pregnant woman in crisis.
B) Nursing interventions that increase knowledge about the crisis situation will increase the client’s ability to cope with the stressor.
C) The nurse has no way of knowing how the situation is going to work out for the client and the baby.
D) Statements of cliches are not supportive and will not help the client’s anxiety after learning about the baby’s potential birth defects.
Page Ref: 2124
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.9. Assess level of patient's decisional conflict and provide access to resources. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Communicate information effectively; listen openly and cooperatively. | Nursing Process: Implementation
Learning Outcome: 31.B. Analyze crisis as it relates to stress and coping. Differentiate considerations for care of patients in crisis across the lifespan.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient in crisis.

WwW.TeSM.Ws

Exemplar 31.C Obsessive-Compulsive Disorder

1) The nurse is concerned that a client is demonstrating signs of obsessive-compulsive disorder (OCD). Which clinical manifestations and risk factors identified during the nursing assessment caused the nurse's concern? **Select all that apply.**
A) Not making eye contact with the nurse
B) Male age 25
C) Client checking the contents of a backpack several times within minutes
D) Client repeating the words "third floor"
E) Client asking to use the bathroom in the middle of the assessment
Answer: B, C, D
Explanation: A) Lack of eye contact is not a manifestation of the disorder.
B) Obsessive-compulsive disorder affects men and women equally; however, men often develop the disorder earlier.
C) Checking is a common compulsion in OCD.
D) Repeating is a common compulsion in OCD.
E) Using the bathroom during an assessment is not a manifestation of the disorder.
Page Ref: 2131
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment

Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Identify the clinical manifestations of OCD.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

2) A mother says to the nurse, "I think my teenage son is showing signs of obsessive-compulsive disorder, just like his father." Which risk factors in the client's medical history would support this diagnosis? **Select all that apply.**
A) Lives with parents
B) Male gender
C) Unemployed
D) History of chronic illnesses
E) Family history
Answer: B, E
Explanation: A) Living with parents is not a risk factor for the disorder.
B) Risk factors for obsessive-compulsive disorder include male gender.
C) Employment status is not a risk factor for obsessive-compulsive disorder.
D) A history of chronic illnesses is not a risk factor for the development of obsessive-compulsive disorder.
E) Risk factors for obsessive-compulsive disorder include having a first-degree relative with the disorder.
Page Ref: 2131
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Compare the risk factors for and prevention of OCD.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

3) When caring for a client newly diagnosed with obsessive-compulsive disorder (OCD), which action by the nurse is appropriate?
A) Do not interrupt the ritual.
B) Interrupt the ritual.
C) Teach about antianxiety foods.
D) Teach ritual interruption skills.
Answer: A
Explanation: A) Do not interrupt the ritual because the client may feel compelled to start from the beginning.
B) Interrupting the ritual creates more anxiety for the client.
C) Teaching about antianxiety foods would not be the priority.
D) Teaching ritual interruption skills would not be the priority.
Page Ref: 2134
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Implementation
Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Apply the nursing process in providing culturally competent care to an individual with OCD.

MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

4) The home care nurse observes a client scrubbing areas throughout the house over and over, especially areas where the family gathers. Prior to planning care for this client, which information should the nurse assess?
A) If the client is forgetful
B) If the client does not clean thoroughly
C) How frequently the client cleans the house
D) The impact of symptoms on the family system
Answer: D
Explanation: A) Forgetfulness is not a component of obsessive-compulsive disorder.
B) How thoroughly the client cleans the house may be important to assess, but it is not the most important.
C) How frequently the client cleans the house may be important to assess, but it is not the most important.
D) Obsessive-compulsive disorder impacts the family system, especially with impaired role function.
Page Ref: 2135
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Threats to the integrity of relationships, and the potential for conflict and abuse. | Nursing Process: Assessment
Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Apply the nursing process in providing culturally competent care to an individual with OCD.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

5) Which finding would indicate that treatment for a client with obsessive-compulsive disorder (OCD) is effective?

A) The client watches television while eating meals and engages in conversation with a roommate.

B) The client conducts ritualistic hand washing every hour.

C) While walking, the client counts 13 steps and then reverses the direction and repeats the process.

D) The client folds and refolds clothing in a drawer before each meal.

Answer: A

Explanation: A) The client who watches television while eating meals and engages in conversation with a roommate is exhibiting behavior that suggests treatment for obsessive-compulsive disorder is effective. This behavior is evidence of reduced anxiety and less of a need to engage in ritualistic behavior.

B) Washing hands every hour indicates the need for additional treatment.

C) Counting 13 steps when walking indicates the need for additional treatment.

D) Folding clothing before meals indicates the need for additional treatment.

Page Ref: 2136

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Evaluation

Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Identify the clinical manifestations of OCD.

MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

6) A client is prescribed fluoxetine (Prozac) for treatment of obsessive-compulsive disorder. During the latest office visit, the client washes the hands while counting to 10 and repeats the process every 5 minutes. Which assessment should the nurse complete as a priority?
A) The amount of medication the client is taking
B) Side effects from the medication the client is experiencing
C) Whether the client is taking the medication as prescribed
D) Foods that may be interacting with the client's medication
Answer: C
Explanation: A) The client would have other signs and symptoms if taking too much medication.
B) Continuing symptoms of obsessive-compulsive disorder is not a side effect of the medication.
C) Fluoxetine (Prozac) is one medication prescribed for the treatment of obsessive-compulsive disorder. Because the client is demonstrating continuing signs of the disorder, the nurse should assess if the client is taking the medication as prescribed.
D) There are no specific foods to avoid when taking this medication.
Page Ref: 2132
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.5. Examine common barriers to active involvement of patients in their own health care processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Assessment
Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with OCD.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

7) The nurse is caring for a client with obsessive-compulsive disorder (OCD). Which nursing intervention is most appropriate when providing care to this client?
A) Confront the client and ask what purpose the behavior serves.
B) Tell the client that the behavior is unacceptable and must end.
C) Interrupt the ritualistic behavior when observed.
D) Discuss the need to incorporate the behavior with other hospital routines.
Answer: D
Explanation: A) The nurse should not confront the client and ask what purpose it serves, as the client might be embarrassed about the behavior.
B) Telling the client that the behavior is unacceptable and must end also will not help the client with the behavior.
C) The nurse should not interrupt the behavior, as this will cause the client to start over from the beginning.
D) The client with obsessive-compulsive behavior will not be able to perform the behavior at will, so the nurse needs to discuss the need to incorporate the behavior with other hospital routines.
Page Ref: 2134
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Implementation

Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Apply the nursing process in providing culturally competent care to an individual with OCD.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

8) A client diagnosed with obsessive-compulsive disorder (OCD) is being admitted as an inpatient. The client is obsessed with thoughts of symmetry. Which compulsive behaviors does the nurse anticipate when performing the admission assessment? **Select all that apply.**

A) The client repeatedly washes his hands.
B) The client repeatedly taps both wrists on the bedside table.
C) The client avoids shaking the nurse's hand.
D) The client begins counting the floor tiles.
E) The client repeatedly cleans the top of the bedside table.

Answer: B, D

Explanation: A) A client whose obsession is cleaning typically demonstrates repetitive performance of decontamination practices, such as repetitive hand washing.

B) Repeatedly tapping both wrists on the bedside table demonstrates common behaviors of a client whose obsession is symmetry. A client whose obsession is symmetry often demonstrates counting, ensuring orderliness of items, or fixation on maintaining symmetrical positioning of items, such as repeatedly tapping both wrists on the bedside table.

C) A client whose obsession is cleaning typically demonstrates repetitive performance of decontamination practices, such avoidance of contamination by refusing to shake hands.

D) Counting the floor tiles demonstrates common behaviors of a client whose obsession is symmetry. A client whose obsession is symmetry often demonstrates counting.

E) A client whose obsession is cleaning typically demonstrates repetitive performance of decontamination practices, such as repetitive environmental cleaning by repeatedly cleaning the top of the bedside table.

Page Ref: 2132

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment

Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Identify the clinical manifestations of OCD.

MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

9) The nurse is providing discharge instructions to a client recently diagnosed with obsessive-compulsive disorder (OCD) and prescribed fluvoxamine (Luvox). Which statement made by the client indicates to the nurse that the client understands the instructions?
A) "I am glad the physician chose this medication because it does not have any side effects."
B) "I should continue taking this medication and in 1-2 years I can stop taking it."
C) "I should continue taking this medication and in 1-2 years my physician may taper me off gradually."
D) "Even though I don't think this medication is for my OCD, I will take it because the physician wants me to."
Answer: C
Explanation: A) Fluvoxamine (Luvox) does have side effects.
B) The client may be tapered off the dose in 1 to 2 years.
C) A client should continue taking fluvoxamine (Luvox) for 1-2 years, at which time a physician may begin gradually tapering, while observing the client for symptom exacerbation.
D) Fluvoxamine (Luvox) is approved by the U.S. Food and Drug Administration (FDA) for treatment of OCD.
Page Ref: 2132
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Communicate information effectively; listen openly and cooperatively. | Nursing Process: Evaluation
Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with OCD.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

10) The nurse is evaluating the plan of care for a client diagnosed with obsessive-compulsive disorder (OCD). Which client statement indicates a positive outcome for the plan of care?
A) "Instead of washing my hands several times a day I use hand sanitizer several times a day."
B) "I am still hand washing frequently, and even though it is less than before, I am a failure."
C) "I am still hand washing frequently but it is less often than before. I think I am improving."
D) "I don't know why I can't wash my hands several times a day; I have nothing else to do anyway."
Answer: C
Explanation: A) The client who has substituted the ritualistic use of hand sanitizer for the ritualistic hand washing has not demonstrated adequate coping skills to control anxiety related to absence of ritualistic compulsive behaviors.
B) Stating that continuing the behavior is a failure does not indicate a positive outcome for care.
C) The client who acknowledges improvement when washing hands less frequently recognizes reductions in behavior signify positive progress.
D) The client who sees nothing wrong with washing hands several times a day does not recognize that the ritualistic hand washing is a problem.
Page Ref: 2136
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Communicate information effectively; listen openly and cooperatively. | Nursing Process: Evaluation

Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Apply the nursing process in providing culturally competent care to an individual with OCD.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

11) A malfunction in which system is thought to contribute to the development of obsessive-compulsive disorder?
A) Frontal-subcortical circuit
B) Hypothalamic-pituitary-adrenal axis
C) Cortico-striato-thalamo-cortical circuit
D) Microbiome-gut-brain axis
Answer: C
Explanation: A) A malfunction in the frontal-subcortical circuit has not been linked to OCD.
B) A malfunction in the hypothalamic-pituitary-adrenal axis has not been linked to OCD.
C) A malfunction in the cortico-striato-thalamo-cortical (CSTC) circuit in the brain is the possible cause for OCD.
D) A malfunction in the microbiome-gut-brain axis has not been linked to OCD.
Page Ref: 2130
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Describe the pathophysiology of OCD.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

12) Which fact should the nurse relay to the young adult who was just diagnosed with obsessive-compulsive disorder (OCD)?
A) Not acting on compulsions is the best cure.
B) Treatment is essential to remission.
C) Recognizing the obsessions as false will lessen their impact.
D) The disorder will gradually get better over time.
Answer: B
Explanation: A) Individuals with OCD perform compulsions to lessen anxiety, and they are often unable to control whether or not they perform the actions.
B) Without treatment, the rate of remission of OCD is estimated to be low. Therefore, treatment is essential.
C) Many individuals with OCD recognize that their obsessive thoughts are false or unlikely to happen, but that does not lessen their impact.
D) The disorder will not usually get better over time without treatment.
Page Ref: 2133
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Describe the etiology of OCD.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

13) For a client with obsessive-compulsive disorder (OCD) with contamination obsessions, which assessment is essential to the development of an effective client care plan?
A) Skin integrity
B) Sexual activity
C) Tics
D) Religious beliefs
Answer: A
Explanation: A) Clients with contamination obsessions often have compulsions related to cleaning and washing, especially washing the hands. Continual exposure to water and cleansing agents may result in loss of skin integrity.
B) Assessment for sexual activity would be more important if the client had sexual obsessions.
C) Assessment for tics would be more important for individuals with symmetry obsessions.
D) Assessment of religious beliefs would be more important if the client had religious obsessions.
Page Ref: 2134
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Apply the nursing process in providing culturally competent care to an individual with OCD.

MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

14) The parent of a school-age child with obsessive-compulsive disorder (OCD) asks why the client has a tantrum when the compulsion is prevented from being performed in public even though the child can perform the compulsion at home. Which response should the nurse make?
A) "It would be best if you don't take your child out in public until control is learned."
B) "Rage attacks by children with OCD are often made worse if the parents accommodate the OCD behaviors."
C) "The best way to prevent the rage attacks is to reinforce the OCD behaviors, especially when in public."
D) "When rage occurs, you need to discipline your child immediately."
Answer: B
Explanation: A) Not taking the child out in public will not be beneficial to the child.
B) Studies indicate that children and adolescents are more likely than adults to suffer rage attacks in relation to their OCD, a phenomenon that is enhanced if their family accommodates or reinforces their OCD behaviors. Telling the parent about this link can help the parents see the need to change their actions, which may eventually help decrease the rage attacks in public.
C) Reinforcing the behaviors in public will not be beneficial to the child.
D) Immediately disciplining the child will not be beneficial to the child.
Page Ref: 2133
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Communicate information effectively; listen openly and cooperatively. | Nursing Process: Implementation
Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Differentiate considerations for care of patients with OCD across the lifespan.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

15) An older client is diagnosed with depression and subclinical obsessive-compulsive symptoms. Which information does the nurse need to consider when planning care for this client?
A) Treatment for the OCD symptoms is not needed because they are subclinical.
B) It may take longer for the client to meet goals than a younger client with similar symptoms.
C) A frequent assessment for signs of dementia is needed.
D) Medication doses will need to be higher than those for a younger client.
Answer: B
Explanation: A) The obsessive-compulsive symptoms need to be treated in the older adult, even though they are subclinical.
B) The comorbidity of obsessive-compulsive symptoms and other mental disorders may interfere with responsiveness to treatment and increase the time it takes for medications to be effective in older adults.
C) Although older adult clients with multiple mental health disorders should be assessed for dementia, the assessments do not need to be performed more frequently than normal.
D) Older adults often need lower doses of medication because of an increased risk of side effects.
Page Ref: 2133
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Planning

Learning Outcome: 31.C. Analyze obsessive-compulsive disorder (OCD) as it relates to stress and coping. Differentiate considerations for care of patients with OCD across the lifespan.
MNL LO: Demonstrate understanding of the concept of stress and coping in the care of a patient with obsessive-compulsive disorder.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 32 Trauma

The Concept of Trauma

1) A young client is brought into the emergency department by a friend who says the client was "beat up" at school. The client has bruising and lacerations to the face and torso. The client is reluctant to provide the names of parents or a home address. Which information can the nurse safely assume about this client?
A) The client does not want the individual who did the beating to get in trouble.
B) The client does not know his parents.
C) The client does not want the school to get in trouble.
D) The client is a victim of interpersonal violence.
Answer: D
Explanation: A) It is unlikely that the client does not want to get the individual who did the beating in trouble.
B) It is unlikely that the client does not know his parents.
C) It is unlikely that the client does not want to get the school in trouble.
D) The client's reluctance to provide parents' names or address could suggest the client is a victim of child abuse from parents rather than a victim of bullying at school.
Page Ref: 2141
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment
Learning Outcome: 32.1. Analyze intentional trauma.
MNL LO: Analyze the concept of trauma and its application to nursing care.

2) A client with a walking disability tells the nurse that going out alone at night is not an option for fear of being a target for a crime. Which has the client identified based on this data?
A) A protective factor
B) A risk factor
C) A vulnerability factor
D) A precipitating factor
Answer: C
Explanation: A) A protective factor decreases the risk of perpetration and victimization.
B) Risk factors increase the potential that one will perpetrate violence on others.
C) Vulnerability factors increase one's risk of being a victim of violence. The client with a walking disability avoids the possibility of a crime by not going out alone at night.
D) Precipitating factors are those that give rise to a specific incident of violence.
Page Ref: 2148
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment
Learning Outcome: 32.5. Summarize health promotion as it relates to trauma.
MNL LO: Analyze the concept of trauma and its application to nursing care.

3) A client is admitted with injuries sustained from a domestic dispute. When planning care, the nurse will include which short-term interventions? **Select all that apply.**

A) Explore options for self-development.
B) Improve quality of life by increasing self-esteem.
C) Explore options for help.
D) Convey right to safety.
E) Determine immediacy of danger.
Answer: C, D, E
Explanation: A) Exploring options for self-development is a long-term intervention for abused adults.
B) Improving the quality of life by increasing self-esteem is a long-term intervention for abused adults.
C) Short-term interventions for abuse include exploring options for help.
D) Short-term interventions for abuse include conveying that the client has the right to be safe.
E) Short-term interventions for abuse include determining the immediacy of danger.
Page Ref: 2149
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Planning
Learning Outcome: 32.7. Analyze independent interventions nurses can implement for patients who have experienced trauma.
MNL LO: Analyze the concept of trauma and its application to nursing care.

4) After an assessment, the nurse suspects a client with multiple injuries is a victim of domestic violence. Which action should occur next?
A) Conducting a team assessment
B) Medicating for anxiety as prescribed
C) Notifying the police
D) Treating the injuries
Answer: A
Explanation: A) Treatment is often done by a team, which means a team assessment needs to be conducted before treatment can take place.
B) The degree of anxiety will determine whether the client needs medication.
C) The police may need to be notified later.
D) If the nursing assessment reveals possible domestic violence, injury treatment will depend upon the assessment from the team members.
Page Ref: 2152
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Implementation
Learning Outcome: 32.8. Summarize collaborative therapies used by interprofessional teams for patients who have experienced trauma.

MNL LO: Analyze the concept of trauma and its application to nursing care.

5) The nurse is caring for a client who is the victim of intimate partner violence and is visited by the partner in the hospital. The client has indicated that she plans to return home when discharged. Which action by the nurse supports the client when the partner is present?
A) Call the police to have the partner arrested for assault.
B) Refuse to permit the partner to visit with the client.
C) Call security to have the partner removed.
D) Ask the client if there is anything that is needed at this time.
Answer: D
Explanation: A) The nurse should not contact police unless requested by the client.
B) The nurse should not refuse to let the partner visit unless it is the client's wish.
C) The nurse should not contact security unless requested by the client.
D) The nurse needs to maintain a nonjudgmental attitude when caring for victims of intimate partner violence and their family members. The nurse should ask the client if there is anything that is needed at this time.
Page Ref: 2149, 2151
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Implementation
Learning Outcome: 32.7. Analyze independent interventions nurses can implement for patients who have experienced trauma.

MNL LO: Analyze the concept of trauma and its application to nursing care.

6) The nurse is providing care to a child who has suffered abuse. Which nursing actions are appropriate? **Select all that apply.**
A) Ask the child what he did to cause his parents to beat him so badly.
B) Tell the child that the individual who hurt them is a bad person.
C) Follow protocols for mandatory reporting.
D) Remind the child that he did nothing wrong.
E) Ask the child what really happened.
Answer: C, D
Explanation: A) The abused child needs to be encouraged to talk about the abuse and not asked specifically what the client did to cause the abuse.
B) The nurse should avoid making negative comments about the abuser.
C) The nurse must follow established protocols for mandatory reporting.
D) The nurse must reassure the child that he or she has done nothing wrong.
E) The nurse working with the abused child needs to say that he or she believes the child's story.
Page Ref: 2152
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Implementation
Learning Outcome: 32.7. Analyze independent interventions nurses can implement for patients who have experienced trauma.

MNL LO: Analyze the concept of trauma and its application to nursing care.

7) A client recovering from surgery for a compound ulnar fracture that occurred during a conflict with the partner says, "I hope this cast comes off before summer. Last night my partner promised to take me to Hawaii this summer. After my jaw was broken last time, I got to go to Rome." Which phase of violence is the client experiencing?

A) The tension phase
B) The abusive phase
C) The honeymoon phase
D) The reconciliation phase

Answer: C

Explanation: A) The tension phase of the cycle of violence occurs when communication fails and tension builds.

B) The abusive phase occurs when there is a violent incident.

C) The honeymoon phase occurs when the aggressor shows love and affection.

D) Reconciliation is not a phase of the cycle of violence.

Page Ref: 2142

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment

Learning Outcome: 32.1. Analyze intentional trauma.

MNL LO: Analyze the concept of trauma and its application to nursing care.

8) The school nurse is leading a discussion on violence with a group of adolescents. Which factors could the school nurse indicate as protective factors that may decrease the risk of violence? **Select all that apply.**
A) Involvement in the community
B) Participation in family activities
C) Residing in an impoverished community
D) Academic failures at a young age
E) Success in school
Answer: A, B, E
Explanation: A) Involvement in the community is a protective factor.
B) Participation in family activities is a protective factor.
C) Residing in an impoverished community is a predisposing factor.
D) Academic failure at a young age is a risk factor for becoming a perpetrator.
E) Success in school is a protective factor.
Page Ref: 2148
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Implementation
Learning Outcome: 32.5. Summarize health promotion as it relates to trauma.
MNL LO: Analyze the concept of trauma and its application to nursing care.

9) A client is brought into the emergency department after being in a motor vehicle crash. The client has suffered traumatic injury that may involve multiple body systems. Which assessment is the highest priority for this client?
A) Breathing and ventilation
B) Circulation with hemorrhage control
C) Airway maintenance with cervical spine protection
D) Disability and neurologic assessment
Answer: C
Explanation: A) Breathing and ventilation is addressed after securing an airway.
B) Circulation is addressed after airway and breathing are ensured.
C) It is imperative that the nurse's first concern be airway maintenance with cervical spine protection.
D) Disability and neurologic assessment are addressed after the airway, breathing, and circulation are ensured.
Page Ref: 2150
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 32.6. Differentiate common assessment procedures and tests used to examine trauma.

MNL LO: Analyze the concept of trauma and its application to nursing care.

10) What type of communication should the nurse employ when caring for a client who has suffered trauma?
A) Assertive communication
B) Therapeutic communication
C) Passive communication
D) Aggressive communication
Answer: B
Explanation: A) Assertive communication may be helpful in some circumstances, but it is not as important as therapeutic communication.
B) Nurses need to employ therapeutic communication to help clients work through the stress and fear of the traumatic event and ultimately accept that the situation they experienced cannot be reversed.
C) Nurses should never use passive communication techniques with clients.
D) Nurses should never use aggressive communication techniques with clients.
Page Ref: 2147
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 32.4. Outline the relationship between trauma and other concepts.
MNL LO: Analyze the concept of trauma and its application to nursing care.

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11) The nurse is caring for several clients in the emergency department. Which individual is a victim of community violence?
A) A 32-year-old woman who was beaten by a partner
B) A 20-year-old man who was shot during a gang dispute
C) A 6-month-old girl who was abused by a parent
D) A 76-year-old man who was neglected at a care facility
Answer: B
Explanation: A) Intimate partner violence is a type of interpersonal violence.
B) Gang violence is a type of community violence, so traumatic injuries sustained during a gang dispute would be categorized as community violence.
C) Violence by a parent is a type of interpersonal violence.
D) Neglect is not a type of violence.
Page Ref: 2144
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Threats to the integrity of relationships, and the potential for conflict and abuse. | Nursing Process: Assessment
Learning Outcome: 32.2. Analyze community and systemic violence.
MNL LO: Analyze the concept of trauma and its application to nursing care.

12) The nurse is caring for a client who was a victim of an assault. Which assessment finding indicates to the nurse that the client has a characteristic of resiliency?
A) Fear
B) Anxiety
C) Optimism
D) Hopelessness
Answer: C
Explanation: A) Fear is not a characteristic of resiliency.
B) Anxiety is not a characteristic of resiliency.
C) Optimism is a factor that can increase resiliency.
D) Hopelessness is not a characteristic of resiliency.
Page Ref: 2149
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 32.3. Analyze unintentional trauma.
MNL LO: Analyze the concept of trauma and its application to nursing care.

Exemplar 32.A Abuse

1) A child is admitted to the hospital with physical injuries. Which assessment findings would indicate that the child is a victim of abuse? **Select all that apply.**
A) Confusion
B) Missing teeth
C) Apprehension when other children cry
D) Abrasions to the mouth, lips, and genitalia
E) Dehydration
Answer: B, C, D
Explanation: A) Confusion is a manifestation of elder abuse.
B) Clinical manifestations of child abuse include missing teeth.
C) Clinical manifestations of child abuse include apprehension when other children cry.
D) Clinical manifestations of child abuse include abrasions to the mouth, lips, and genitalia.
E) Dehydration is a manifestation of elder abuse.
Page Ref: 2159
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment
Learning Outcome: 32.A. Analyze abuse as it relates to trauma. Identify the clinical manifestations of abuse.

MNL LO: Demonstrate understanding of the concept of trauma in the care of the abused patient.

2) The nurse is providing care for a 2-year-old client. When assessing the client's risk for abuse, which factors increase this client's risk? **Select all that apply.**
A) The child has bruises on the knees and shins.
B) The child's parents are married.
C) The child is less than 3 years old.
D) The child is deaf.
E) The child's parents are unemployed and receive medical assistance.
Answer: C, D, E
Explanation: A) Bruises on the knees and shins are not risk factors for abuse.
B) Marriage of the parents is not a risk factor for abuse.
C) Risk factors for child abuse include age less than 3 years.
D) Risk factors for child abuse include child disability or condition that requires a great deal of care.
E) Risk factors for child abuse include poverty.
Page Ref: 2156-2157
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment
Learning Outcome: 32.A. Analyze abuse as it relates to trauma. Compare the risk factors and prevention of abuse.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the abused patient.

3) A client with a long history of experiencing intimate partner violence says, "There is no way out for me; this situation will never change." Which problem should the nurse use to plan care for this client?
A) Powerlessness
B) Acute pain
C) Sexual dysfunction
D) Social isolation
Answer: A
Explanation: A) Powerlessness is indicated when the client feels an inability to change the pattern or to leave the situation.
B) There is no evidence that the client is experiencing pain.
C) There is no evidence that the client is experiencing sexual dysfunction.
D) There is no evidence that the client is experiencing social isolation.
Page Ref: 2163
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Diagnosis
Learning Outcome: 32.A. Analyze abuse as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual who has been abused.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the abused patient.

4) The nurse is providing care for a client who experienced several fractures as a result of intimate partner violence. Which intervention is the most appropriate to include when planning care for the client?
A) Assist the client to devise a safety or escape plan.
B) Encourage the client to take charge of the situation.
C) Offer to contact outpatient services if the client promises not to return home after discharge.
D) Make it clear to the spouse that the couple needs to see a therapist.
Answer: A
Explanation: A) A client who has been victimized by a partner should have a safety plan. This has the highest priority as the client's life is in danger.
B) Encouraging the client to take charge is too general a statement to be helpful; the client needs specific tools to develop a safety plan.
C) Resources should not be withheld if a client is unable to promise not to return home.
D) Suggesting that the couple needs to see a therapist may escalate the situation.
Page Ref: 2163
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Planning
Learning Outcome: 32.A. Analyze abuse as it relates to trauma. Compare the risk factors and prevention of abuse.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the abused patient.

5) A client who has experienced domestic violence in the past has decided to stop participating in counseling. Which client statement would indicate that therapy has been effective?
A) "Everyone knows what my problems are, and there is nothing I can do about it."
B) "I am functioning fine now, but I know that when problems come up again, I will ask for help."
C) "My friends tell me that I have improved so this is a good time to stop."
D) "It is so draining to deal with the same painful issues all of the time."
Answer: B
Explanation: A) Stating that there is nothing than can be done is fatalistic.
B) The client acknowledging that future problems will come up indicates that the client has gained insight into problems. The client's willingness to ask for help shows that the client is prepared to continue with counseling when new problems arise.
C) Basing termination of treatment on the statements of others places emphasis on others and not on self-evaluation.
D) Stating that the process is draining and painful suggests that little progress has been made and that the client is looking to avoid the pain.
Page Ref: 2164
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Evaluation
Learning Outcome: 32.A. Analyze abuse as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual who has been abused.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the abused patient.

6) An older adult client is brought into the emergency room after experiencing a fall. The nurse suspects elder abuse. Which assessment findings support the nurse's suspicions? **Select all that apply.**
A) Poor hygiene
B) Dehydration
C) Intracranial trauma
D) Fecal impaction
E) Dislocations
Answer: A, B, D, E
Explanation: A) The nurse suspecting elder abuse would assess for clinical manifestations associated with elder abuse. One of those clinical manifestations is poor hygiene.
B) The nurse suspecting elder abuse would assess for clinical manifestations associated with elder abuse. One of those clinical manifestations is dehydration.
C) Intracranial trauma is not a typical clinical manifestation of elder abuse; however, it is a clinical manifestation of child abuse.
D) The nurse suspecting elder abuse would assess for clinical manifestations associated with elder abuse. One of those clinical manifestations is fecal impaction.
E) The nurse suspecting elder abuse would assess for clinical manifestations associated with elder abuse. One of those clinical manifestations is dislocations.
Page Ref: 2160
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment
Learning Outcome: 32.A. Analyze abuse as it relates to trauma. Identify the clinical manifestations of abuse.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the abused patient.

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7) The nurse is completing a morning assessment on an older adult Asian client. Assessment findings reveal circular red welts over the client's upper back with several bruised areas. Which nursing action is the most appropriate?
A) Contact adult protective services.
B) Call the healthcare provider immediately.
C) Assess the client's cultural traditions.
D) Contact the client's family.
Answer: C
Explanation: A) Adult protective services does not need to be contacted.
B) The healthcare provider does not need to be contacted.
C) The most appropriate action for the nurse at this time is to assess the client's cultural traditions. The practice of cupping is generally practiced by many Asian cultures, as well as individuals who participate in holistic healing. Cupping is the act of placing a glass cup on the skin, and then using heat to create suction; often this is performed to promote blood flow and overall healing. The result of the procedure can be circular red welts or even dark bruising, which are often found along the individual's back.
D) The client's family does not need to be contacted. The most appropriate action for the nurse at this time is to assess the client's spiritual beliefs. The practice of cupping is generally practiced by many Asian cultures, as well as individuals who participate in holistic healing. Cupping is the act of placing a glass cup on the skin, and then using heat to create suction; often this is performed to promote blood flow and overall healing. The result of the procedure can be circular red welts or even dark bruising, which are often found along the individual's back. This treatment is not abusive in nature, but rather a form of healing.
Page Ref: 2161

Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Show respect for others' values; appreciate diversity; be civil during relationships and work. | Nursing Process: Implementation
Learning Outcome: 32.A. Analyze abuse as it relates to trauma. Identify the clinical manifestations of abuse.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the abused patient.

8) A pediatric nurse is caring for an 8-month-old client. While making rounds, the nurse enters the room and finds the infant's father violently shaking the infant. The father attempts to make it appear as though the infant was choking. Upon further assessment, the nurse notes bruised areas on the infant's arms and legs. Which action should the nurse take?
A) Discuss what the nurse witnessed with the infant's mother.
B) Discuss what the nurse witnessed with the other nurses.
C) Report what the nurse witnessed and assessed to the authorities.
D) Call security to remove the father from the room.
Answer: C
Explanation: A) It would not be appropriate at this time to discuss the findings with the infant's mother.
B) It would not be appropriate at this time to discuss the findings with other nurses.
C) Because of mandatory reporting laws, nurses must report all suspected cases of child abuse to the appropriate authorities.
D) The nurse should not call security to remove the father from the room until after the abuse has been reported.
Page Ref: 2159
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Implementation

Learning Outcome: 32.A. Analyze abuse as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual who has been abused.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the abused patient.

9) Which finding is a common element of abuse experienced by the victim?
A) Injuries
B) Feelings of control
C) Humiliation
D) Manipulation
Answer: A
Explanation: A) Common elements of abuse include injuries in some form.
B) Victims of abuse do not feel in control.
C) Humiliation is not a common finding in victims of abuse.
D) Manipulation is not a common finding among victims of abuse.
Page Ref: 2159-2160
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment
Learning Outcome: 32.A. Analyze abuse as it relates to trauma. Describe the pathophysiology of abuse.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the abused patient.

10) Which theory states that individuals learn violent tendencies through association with others and a reinforcement of abusive behaviors?

A) Social learning theory
B) Psychopathology theory
C) Neurobiology theory
D) Social-ecologic model
Answer: A
Explanation: A) Social learning theory explains that individuals learn violent tendencies through association with others and a reinforcement of the abusive behavior.
B) Psychopathology is not a theory identified to explain abusive behaviors.
C) Neurobiology theory asserts that genetics plays a role in anger modulation and emotion control.
D) The social-ecologic model is used to understand how various personal and environmental factors interrelate and influence violent behaviors.
Page Ref: 2156
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationship between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 32.A. Analyze abuse as it relates to trauma. Describe the etiology of abuse.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the abused patient.

11) Which diagnostic test might the healthcare team use to determine the full extent of an abuse victim's injuries if the victim complains of abdominal pain?
A) Ultrasound
B) X-ray
C) MRI
D) Blood test
Answer: A
Explanation: A) An ultrasound or CT scan of the abdomen can check for abdominal or organ injuries.
B) X-rays can detect fractured bones.
C) An MRI of the spine will show spinal injuries.
D) Blood tests may be used to detect sexually transmitted diseases.
Page Ref: 2162
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 32.A.6. Analyze abuse as it relates to trauma. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual who has been abused.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the abused patient.

Exemplar 32.B Multisystem Trauma

1) An older adult man is transported to the emergency department after a motor vehicle crash. Which risk factors for the older adult could have contributed to the crash? **Select all that apply.**
A) Unsafe driving practices
B) Decline in cognitive function
C) Speeding
D) Texting
E) Vision changes
Answer: B, E
Explanation: A) Younger adults are at risk of motor vehicle crashes due to unsafe driving practices.
B) Older adults are at risk of motor vehicle crashes due to decline in cognitive function.
C) Younger adults are at risk of motor vehicle crashes due to speeding.
D) Younger adults are at risk of motor vehicle crashes due to texting or other distractions.
E) Older adults are at risk of motor vehicle crashes due to changes in vision.
Page Ref: 2166
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment
Learning Outcome: 32.B. Analyze multisystem trauma as it relates to trauma. Differentiate care of patients with multisystem trauma across the lifespan.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with multisystem trauma.

2) The nurse is planning care for a client with multiple lower extremity fractures sustained from a motor vehicle crash. Which goal should the nurse use to plan care?
A) The client will have adequate urine output.
B) The client will regain mobility.
C) The client will participate in self-care activities.
D) The client will be discharged to home.
Answer: B
Explanation: A) An adequate urine output is important, but healing the client's fractures needs to be a goal of care.
B) The client has sustained multiple lower extremity fractures. A goal of care for this client is for the client to regain mobility.
C) Participating in self-care activities is important; however, because the client sustained multiple fractures to the lower extremities, one goal of care must be focused on the client regaining mobility.
D) Being discharged to home is important; however, because the client sustained multiple fractures to the lower extremities, one goal of care must be focused on the client regaining mobility.
Page Ref: 2171
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Planning

Learning Outcome: 32.B. Analyze multisystem trauma as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual with multisystem trauma.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with multisystem trauma.

3) A client was admitted to the hospital after a crush injury to the chest. The client sustained multiple rib fractures, a collapsed lung, and several skin abrasions. After the client is stabilized, which nursing intervention would be a priority for this client?
A) Monitor urine output.
B) Assess vital signs.
C) Perform passive range of motion to all extremities.
D) Assist to take deep breaths and cough every 2 hours.
Answer: D
Explanation: A) Monitoring urine output is not the priority at this time.
B) Assessing vital signs is not the priority at this time.
C) The client may be able to perform active range of motion for all extremities, so this intervention may or may not be indicated.
D) The client has thoracic injuries and might be reluctant to take deep breaths and cough because of pain. The nurse needs to ensure that the client breathes deeply and coughs every 2 hours to mobilize secretions and prevent respiratory complications.
Page Ref: 2168, 2172
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise and evidence. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Factors that contribute to or threaten health. | Nursing Process: Implementation
Learning Outcome: 32.B. Analyze multisystem trauma as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual with multisystem trauma.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with multisystem trauma.

4) A client is admitted to the emergency department with an incomplete spinal cord injury after a fall from a roof. Which prescription does the nurse anticipate to decrease inflammation and nerve damage?
A) Hydrocodone (Vicodin)
B) Ibuprofen (Motrin)
C) Methylprednisolone (Medrol)
D) Xylocaine (Lidocaine)
Answer: C
Explanation: A) Hydrocodone (Vicodin) is a pain relief medication.
B) Ibuprofen (Motrin) is an anti-inflammatory given to clients to reduce swelling, such as joint swelling.
C) Methylprednisolone (Medrol) is given to clients with spinal cord injuries to decrease inflammation and prevent nerve damage.
D) Xylocaine (Lidocaine) is injected into the affected muscle to relieve pain and muscle spasms, such as muscle spasms related to whiplash.
Page Ref: 2168
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 32.B. Analyze multisystem trauma as it relates to trauma. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with multisystem trauma.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with multisystem trauma.

5) The nurse is developing a plan of care for a client with traumatic injuries after a natural disaster. Which nursing intervention does the nurse include in the plan of care to reduce the risk of integumentary complications?
A) Provide active or passive exercises at least once every 8 hours.
B) Encourage coughing, deep breathing, and incentive spirometry.
C) Assist the client in turning at least every 2 hours.
D) Assist the client in turning at least every 8 hours.
Answer: C
Explanation: A) Encouraging exercise improves muscle tone but does not reduce the risk of integumentary complications.
B) Encouraging coughing and deep breathing reduces the risk of respiratory complications.
C) Assisting the client to turn at least every 2 hours is the most appropriate intervention for the nurse to include in the plan of care to reduce the risk of integumentary complications.
D) Turning the client every 8 hours will not reduce the risk of integumentary complications.
Page Ref: 2172
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise and evidence. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 32.B. Analyze multisystem trauma as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual with multisystem trauma.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with multisystem trauma.

6) Which care would the nurse make a priority when caring for a client with traumatic injuries?
Select all that apply.
A) Airway maintenance
B) Obtaining medical history
C) Ventilation assistance
D) Hemorrhage control
E) Hypothermia prevention
Answer: A, C, D, E
Explanation: A) Clinical priorities for the treatment of traumatic injures include airway maintenance.
B) While obtaining the client's medical history is important, this action would not be priority and would take place after the priority assessment and treatment.
C) Clinical priorities for the treatment of traumatic injuries include ensuring ventilation.
D) Clinical priorities for the treatment of traumatic injuries include controlling bleeding and ensuring circulation.
E) Clinical priorities for the treatment of a client with traumatic injuries is preventing hypothermia.
Page Ref: 2170-2171
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Assessment
Learning Outcome: 32.B. Analyze multisystem trauma as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual with multisystem trauma.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with multisystem trauma.

7) A client is brought into the emergency department after being assaulted. The provider suspects that the client has a spinal cord injury. Which diagnostic tests does the nurse anticipate based on the data collected? **Select all that apply.**
A) Computed tomography (CT) scan
B) X-ray
C) Ultrasound
D) Magnetic resonance imaging (MRI)
E) Positron emission tomography (PET) scan
Answer: A, D
Explanation: A) CT scans can be used to assess spinal cord injuries, among other injuries.
B) An x-ray will be performed for potential fractured bones.
C) An ultrasound is performed if internal bleeding is suspected.
D) MRIs scans can be used to assess spinal cord injuries, among other injuries.
E) A PET scan is used to look for disease within the main organs of the body
Page Ref: 2169
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 32.B. Analyze multisystem trauma as it relates to trauma. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual with multisystem trauma.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with multisystem trauma.

8) Which cause of multisystem trauma is the leading cause of injury death in the United States?
A) Poisonings
B) Motor vehicle crashes
C) Assault
D) Natural disasters
Answer: A
Explanation: A) Poisonings are the leading cause of injury death in the United States.
B) Motor vehicle crashes are the second leading cause of unintentional deaths in the United States.
C) Assault is not a leading cause of injury death.
D) Natural disasters are not leading causes of injury death.
Page Ref: 2165
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 32.B. Analyze multisystem trauma as it relates to trauma. Describe the etiology of multisystem trauma.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with multisystem trauma.

9) A client lost consciousness after being hit by a falling piece of equipment on a work site. Which type of injury should the nurse assess this client for as the highest priority?
A) Fractured bones
B) Traumatic brain injury
C) Whiplash
D) Spinal cord injury
Answer: B
Explanation: A) Fractured bones may need to be assessed depending on the location of the injury and the client's other clinical manifestations, but this would be a lower priority than assessing for traumatic brain injury.
B) Loss of consciousness is a sign of traumatic brain injury, and any injury to the brain should be assessed with highest priority.
C) Whiplash usually results from a motor vehicle crash, so assessing for whiplash would be low in priority.
D) Spinal cord injury may need to be assessed depending on the location of the injury and the client's other clinical manifestations, but this would be a lower priority than assessing for traumatic brain injury.
Page Ref: 2167
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 32.B. Analyze multisystem trauma as it relates to trauma. Identify the clinical manifestations of multisystem trauma.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with multisystem trauma.

10) If a pregnant woman sustains multisystem trauma, in which order should assessment occur?
A) Primary assessment of the mother, secondary assessment of the mother, primary assessment of the fetus
B) Primary assessment of the mother, primary assessment of the fetus, secondary assessment of the mother
C) Primary assessment of the fetus, primary assessment of the mother, secondary assessment of the mother
D) Primary assessment of the fetus, primary assessment of the mother, secondary assessment of the fetus
Answer: B
Explanation: A) If a pregnant woman sustains multisystem trauma, the mother is not given a primary and secondary assessment before the fetus.
B) If a pregnant woman sustains multisystem trauma, the best treatment for the fetus is resuscitation of the mother. Therefore, the mother should be assessed first, then the fetus. Once both have been assessed and stabilized, then the secondary assessment of the mother should be performed.
C) If a pregnant woman sustains multisystem trauma, the fetus is not assessed first.
D) If a pregnant woman sustains multisystem trauma, the fetus is not assessed first, nor is there is a primary and secondary assessment of the fetus.
Page Ref: 2170
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise and evidence. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 32.B. Analyze multisystem trauma as it relates to trauma. Differentiate care of patients with multisystem trauma across the lifespan.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with multisystem trauma.

Exemplar 32.C Posttraumatic Stress Disorder

1) During the assessment, the nurse observes a client who was a victim of a home invasion abruptly stand up and begin to run out of the room in response to hearing a loud bang. Which should the nurse assume regarding the client's behavior?
A) The client thought there was an earthquake.
B) The client was reacting to the loud noise as a form of a flashback.
C) The client wanted to check the cause of the loud noise.
D) The client thought the assessment was concluded.
Answer: B
Explanation: A) The client most likely did not think that there was an earthquake.
B) Flashbacks are the recurrence of images, sounds, smells, or feelings from a traumatic event that are triggered by daily events such as a door banging. The client's reaction to hearing a loud bang from a door could have made the client recall being at home during the home invasion.
C) The client would not have abruptly begun to run out of the room if checking for the source of the loud noise.
D) The client most likely did not think that the assessment was concluded.
Page Ref: 2176
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 32.C. Analyze posttraumatic stress disorder (PTSD) as it relates to trauma. Describe the pathophysiology of PTSD.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with posttraumatic stress disorder.

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2) The nurse suspects a client is experiencing posttraumatic stress disorder when which are noted during the assessment process? **Select all that apply.**

A) Observed family member being raped and murdered
B) Restores antique automobiles as a hobby
C) Lives with spouse and has a garden
D) Has a history of anxiety disorder
E) Recently terminated from employment

Answer: A, D, E

Explanation: A) Risk factors for the development of posttraumatic stress disorder include watching others be harmed or killed.

B) Engaging in hobbies are not risk factors for the disorder.

C) Engaging in hobbies and living with a spouse are not risk factors for the disorder.

D) Risk factors for the development of posttraumatic stress disorder include the presence of a preexisting mental illness.

E) Risk factors for the development of posttraumatic stress disorder include the stress associated with the loss of employment.

Page Ref: 2176

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies:AACN Domains and Competencies: 2.3 Integrate assessment skills in practice.NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment

Learning Outcome: 32.C. Analyze posttraumatic stress disorder (PTSD) as it relates to trauma. Compare the risk factors and prevention of PTSD.

MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with posttraumatic stress disorder.

3) A client witnessed a violent bank robbery. Which assessment findings would indicate that the client is experiencing posttraumatic stress disorder (PTSD)? **Select all that apply.**

A) Difficulty sleeping
B) Hypovigilance
C) Alcohol abuse
D) Aggressive behavior
E) Hair pulling

Answer: A, C, D

Explanation: A) Difficulty sleeping is a clinical manifestation of posttraumatic stress disorder.
B) Hypervigilance, not hypovigilance, is associated with PTSD.
C) Alcohol abuse is a clinical manifestation of posttraumatic stress disorder.
D) Aggressive behavior is a clinical manifestation of posttraumatic stress disorder.
E) Hair pulling is not a symptom of PTSD.

Page Ref: 2177

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment

Learning Outcome: 32.C. Analyze posttraumatic stress disorder (PTSD) as it relates to trauma. Identify the clinical manifestations of PTSD.

MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with posttraumatic stress disorder.

4) A client tells the nurse about continually reliving a situation of being robbed and shot by a gunman. Which problem is the priority for this client?
A) Hopelessness
B) Helplessness
C) Potential for violence against self or others
D) Inadequate coping skills or resources
Answer: C
Explanation: A) The client reliving a traumatic event does not indicate hopelessness.
B) The client reliving a traumatic event does not indicate helplessness.
C) The client is reliving a traumatic event and has nightmares of being shot. This information would support the potential for violence against self or others.
D) The client reliving a traumatic event does not indicate inadequate coping skills or resources.
Page Ref: 2179
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Diagnosis
Learning Outcome: 32.C. Analyze posttraumatic stress disorder (PTSD) as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual with PTSD.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with posttraumatic stress disorder.

5) The nurse is caring for a client who was diagnosed with posttraumatic stress disorder 4 months ago. Which should the nurse include in the client's plan of care?
A) Guidelines on conducting activities of daily living
B) Information on the treatments available
C) Referral to local employment agency
D) Information on the need for adequate exercise
Answer: B
Explanation: A) Information on activities of daily living will most likely not help the client's symptoms.
B) The nurse should plan to provide the client with information on the treatments available for posttraumatic stress disorder.
C) Referral to the local employment agency may or may not be necessary.
D) Information on exercise will most likely not help the client's symptoms.
Page Ref: 2179
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Planning
Learning Outcome: 32.C. Analyze posttraumatic stress disorder (PTSD) as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual with PTSD.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with posttraumatic stress disorder.

6) The nurse is reviewing the effectiveness of care provided to a client diagnosed with posttraumatic stress disorder. Which outcomes would indicate the interventions in the plan of care have been effective? **Select all that apply.**
A) The client takes a sedative at least four times a day.
B) The client has been sleeping throughout the night.
C) The client keeps all of the lights on at home.
D) The client verbalizes future plans with family and friends.
E) The client will not enter a car with fewer than three people.
Answer: B, D
Explanation: A) The client who takes sedatives four times a day is exhibiting behavior that indicates interventions have not been successful.
B) Evidence of effective intervention for posttraumatic stress disorder would be the client being able to sleep throughout the night.
C) The client who keeps all of the lights on in the home, is exhibiting behavior that indicates interventions have not been successful.
D) Evidence of effective intervention for posttraumatic stress disorder would be the client verbalizing future plans with family and friends.
E) The client who is unable to enter a car with fewer than three people is exhibiting behavior that indicates interventions have not been successful.
Page Ref: 2180
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1 Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Evaluation
Learning Outcome: 32.C. Analyze posttraumatic stress disorder (PTSD) as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual with PTSD.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with posttraumatic stress disorder.

7) Which nursing interventions would be appropriate for a client demonstrating extreme anxiety related to posttraumatic stress disorder (PTSD)? **Select all that apply.**
A) Encourage the client to discuss what caused the syndrome to develop.
B) Provide a calm, quiet environment.
C) Give the client paperwork to complete while waiting to be assessed.
D) Ask the client what is causing the anxiety.
E) Reassure the client that the environment is safe.
Answer: B, E
Explanation: A) Encouraging the client to discuss what caused the syndrome to develop is not an effective intervention for acute anxiety related to this disorder and should not be done.
B) The client diagnosed with PTSD who is exhibiting extreme anxiety needs a quiet and calm environment.
C) The client should not be given paperwork to complete.
D) Asking the client what is causing the anxiety is not an effective intervention for acute anxiety related to this disorder and should not be done.
E) The client diagnosed with PTSD who is exhibiting extreme anxiety needs reassurance of their safety.
Page Ref: 2176
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Implementation
Learning Outcome: 32.C. Analyze posttraumatic stress disorder (PTSD) as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual with PTSD.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with posttraumatic stress disorder.

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8) A client with posttraumatic stress disorder (PTSD) reports frequent nightmares. Which medication prescription does the nurse anticipate for this client?
A) Propranolol
B) Prazosin
C) Risperidone
D) Fluvoxamine
Answer: B
Explanation: A) Propranolol is a beta-blocker.
B) Prazosin is an antihypertensive medication that may be prescribed for treatment and prevention of nightmares.
C) Risperidone is an antipsychotic.
D) Fluvoxamine is a selective serotonin reuptake inhibitor (SSRI) that may be used in the treatment of OCD.
Page Ref: 2177
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Planning
Learning Outcome: 32.C. Analyze posttraumatic stress disorder (PTSD) as it relates to trauma. Summarize therapies used by interprofessional teams in the collaborative care of an individual with PTSD.

MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with posttraumatic stress disorder.

9) The nurse is developing a plan of care for a client diagnosed with posttraumatic stress disorder (PTSD). The client was recently admitted to the hospital for suicidal ideations and sleep disturbance due to frequent nightmares. Which goal should be included in the client's plan of care?
A) The client will report a reduction in, or cessation of, nightmares.
B) The client will report a decreased perception of anxiety.
C) The client will discuss emotions related to traumatic experiences.
D) The client will remain free from injury or harm.
Answer: D
Explanation: A) A reduction or cessation of nightmares is not the client's major problem.
B) Anxiety is not the client's major problem.
C) Emotions related to traumatic experiences is not the client's major problem.
D) Ensuring that the client remains free of injury would be the priority goal. The client was admitted with thoughts of suicide, and this places the client at risk for harm or self-injury. Safety is a priority.
Page Ref: 2179
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Planning
Learning Outcome: 32.C. Analyze posttraumatic stress disorder (PTSD) as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual with PTSD.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with posttraumatic stress disorder.

10) The nurse is developing a plan of care for a client diagnosed with posttraumatic stress disorder (PTSD) who was admitted to the hospital for suicidal ideations and sleep disturbance due to frequent nightmares. Which is the priority problem for this client?
A) Sleep disturbance
B) Anxiety
C) Fear
D) Potential for violence against self or others
Answer: D
Explanation: A) Sleep disturbance is not the client's primary problem because it would not hinder the client's safety.
B) Anxiety is not the client's primary problem.
C) Fear is not the client's primary problem.
D) Potential for violence against self or others is the primary problem because the client is experiencing thoughts of suicide.
Page Ref: 2179
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Diagnosis
Learning Outcome: 32.C. Analyze posttraumatic stress disorder (PTSD) as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual with PTSD.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with posttraumatic stress disorder.

11) Which individual has the highest risk of developing PTSD?
A) Victim of assault
B) Natural disaster survivor
C) Motor vehicle crash survivor
D) Military veteran
Answer: D
Explanation: A) A victim of assault has a lower risk of developing PTSD than another population.
B) A natural disaster survivor has a lower risk of developing PTSD than another population.
C) A motor vehicle crash survivor has a lower risk of developing PTSD than another population.
D) Although all of these individuals may develop PTSD, the incidence of PTSD is particularly high among military personnel who have been deployed in overseas combat.
Page Ref: 2176
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 32.C. Analyze posttraumatic stress disorder (PTSD) as it relates to trauma. Describe the etiology of PTSD.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with posttraumatic stress disorder.

12) Which form of therapy might be used to help an individual with posttraumatic stress disorder (PTSD) visit the location where a traumatic event occurred?

A) Cognitive-behavioral therapy

B) Dual attention stimulus therapy

C) EMDR therapy

D) Exposure therapy

Answer: D

Explanation: A) Cognitive-behavioral therapy (CBT) does not involve visiting the location where the traumatic event occurred.

B) Dual attention stimulus does not involve visiting the location where the traumatic event occurred.

C) Eye movement desensitization and reprocessing (EMDR) does not involve visiting the location where the traumatic event occurred.

D) Exposure therapy assists the patient by gradually exposing them to elements of the traumatic event using writing, pictures, and visiting the place where the traumatic event occurred.

Page Ref: 2177

Cognitive Level: Understanding

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Implementation

Learning Outcome: 32.C. Analyze posttraumatic stress disorder (PTSD) as it relates to trauma. Summarize therapies used by interprofessional teams in the collaborative care of an individual with PTSD.

MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with posttraumatic stress disorder.

13) The nurse is assessing a 4-year-old child. Which assessment finding indicates to the nurse that the child might have suffered a traumatic event?
A) Refuses to talk or answer questions when previously the child chatted constantly.
B) Draws pictures of family when previously the child drew pictures of animals.
C) Complains of a stomachache and has a fever.
D) Plays quietly in a corner when previously the child sat on his mother's lap.
Answer: A
Explanation: A) Forgetting how to talk or not talking at all are signs of posttraumatic stress disorder (PTSD) in children.
B) A child with PTSD may draw pictures that symbolize the trauma, not simple pictures of family or animals.
C) Somatic complaints are more common in older adults with PTSD and likely indicate conditions other than PTSD in young children.
D) Children with PTSD may behave recklessly or aggressively, not play quietly.
Page Ref: 2178
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1 Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 32.C. Analyze posttraumatic stress disorder (PTSD) as it relates to trauma. Differentiate care of patients with PTSD across the lifespan.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with posttraumatic stress disorder.

14) The nurse is assessing two clients: a 23-year-old man who recently returned from overseas deployment with the military and a 68-year-old man who served in the military during the Vietnam War. Both clients have been diagnosed with posttraumatic stress disorder (PTSD). Which statement did the nurse likely record from the 68-year-old man?
A) "I startle at every sudden noise I hear whether it is loud or quiet."
B) "I haven't had much of an appetite lately and am achy."
C) "I just want to go out and hit someone."
D) "I feel so guilty that I came home and three of my good buddies didn't."
Answer: B
Explanation: A) Older veterans are less likely to have typical PTSD symptoms such as an exaggerated startle response.
B) Older veterans may report more somatic complaints, such as loss of appetite and aches than younger veterans with PTSD.
C) Older veterans are less likely to have typical PTSD symptoms such as hostility.
D) Older veterans are less likely to have typical PTSD symptoms such as guilt than younger veterans with PTSD.
Page Ref: 2178
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 32.C. Analyze posttraumatic stress disorder (PTSD) as it relates to trauma. Differentiate care of patients with PTSD across the lifespan.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient with posttraumatic stress disorder.

Exemplar 32.D Sexual Violence

1) The nurse is caring for a victim of sexual assault. Which interventions should the nurse include in the client's plan of care? **Select all that apply.**
A) Notifying an attorney for the client
B) Supporting the victim during the examination
C) Identifying the individual who committed the assault
D) Treating acute injuries
E) Providing referrals for follow-up care
Answer: B, D, E
Explanation: A) Nursing priorities do not include notifying an attorney for the client.
B) Priorities of nursing care include supporting the victim during the examination.
C) Nursing priorities do not include identifying the individual who committed the assault.
D) Priorities of nursing care include treating any acute injuries.
E) Priorities of nursing care include providing referrals for follow-up care.
Page Ref: 2184
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Planning
Learning Outcome: 32.D. Analyze sexual violence as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual who has experienced sexual violence.

MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient dealing with sexual violence.

2) A client who was a victim of sexual assault wants a bed by the door. Which problem is a priority for the client?
A) Acute pain
B) Fear
C) Powerlessness
D) Potential for low self-esteem
Answer: B
Explanation: A) There is no evidence that the client is experiencing pain.
B) The client who was a victim of sexual assault is asking for a bed by the door. This indicates fearfulness.
C) There is no evidence that the client is experiencing powerlessness.
D) There is no evidence that the client is experiencing low self-esteem.
Page Ref: 2188
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Diagnosis
Learning Outcome: 32.D. Analyze sexual violence as it relates to trauma. Identify the clinical manifestations of sexual violence.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient dealing with sexual violence.

3) The nurse is providing care for a client who was the victim of sexual assault 8 months ago. Which ongoing, long-term treatment goals are appropriate? **Select all that apply.**
A) The client's symptoms of anger and fear will resolve.
B) The client will involve significant others in the treatment plan.
C) The client will be able to verbalize legal rights.
D) The client will establish rapport and build a trusting nurse—client relationship.
E) The client will increase the ability to trust and attach to others.
Answer: A, E
Explanation: A) Decreasing symptoms of anger and fear may take months or years.
B) The nurse should have involved significant others in the treatment plan.
C) The nurse should have made the client aware of legal rights immediately after the sexual assault occurred.
D) The nurse should have established rapport immediately after the sexual assault occurred.
E) Trusting and attaching with others may take months or years.
Page Ref: 2189
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Planning
Learning Outcome: 32.D. Analyze sexual violence as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual who has experienced sexual violence.

MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient dealing with sexual violence.

4) A client recovering from sexual violence reports flashbacks do occur but can be managed. Which techniques should the nurse suggest to the client for managing flashbacks about the event? **Select all that apply.**

A) Restoring personal choice
B) Deep breathing
C) Muscle relaxants
D) Problem solving
E) Guided imagery

Answer: B, E

Explanation: A) Restoring personal choice supports coping behaviors.
B) Techniques that the client can use to control flashbacks include deep breathing.
C) Muscle relaxants are not identified to reduce flashbacks.
D) Problem solving is a technique to support coping behaviors.
E) Techniques that the client can use to control flashbacks include guided imagery.

Page Ref: 2140

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Implementation

Learning Outcome: 32.D. Analyze sexual violence as it relates to trauma. Apply the nursing process in providing culturally competent care to an individual who has experienced sexual violence.

MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient dealing with sexual violence.

5) A client who was a victim of sexual violence says she must not get pregnant. Which response by the nurse is appropriate?
A) "The baby could always be given up for adoption."
B) "You will not know for sure for at least a few more days."
C) "Emergency contraception is available to prevent pregnancy."
D) "Are you sure the rapist did not use a condom?"
Answer: C
Explanation: A) The nurse should not talk about giving a baby up for adoption at this time.
B) The nurse should not tell the client that it will be a few more days to know for sure if she is pregnant.
C) Victims of sexual violence may request information about emergency contraception if the attacker did not use a condom.
D) The nurse should not question whether the rapist used a condom.
Page Ref: 2187
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.1. Elicit patient values, preferences and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Implementation
Learning Outcome: 32.D. Analyze sexual violence as it relates to trauma. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual who has experienced sexual violence.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient dealing with sexual violence.

6) The nurse working in the emergency department is aware that victims of sexual violence exhibit which psychologic injuries? **Select all that apply.**
A) Phobias
B) Flashbacks
C) Depression
D) Panic attacks
E) Thoughts of suicide
Answer: B, C, E
Explanation: A) Phobias are psychologic injuries associated with sex trafficking.
B) Flashbacks are psychologic injuries associated with sexual assault.
C) Depression is a psychologic injury associated with sexual assault.
D) Panic attacks are psychologic injuries associated with sex trafficking.
E) Thoughts of suicide is a psychologic injury associated with sexual assault.
Page Ref: 2184
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment
Learning Outcome: 32.D. Analyze sexual violence as it relates to trauma. Identify the clinical manifestations of sexual violence.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient dealing with sexual violence.

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7) A victim of sexual assault is diagnosed with syphilis. Which prescription does the nurse anticipate for this client?
A) Penicillin
B) Ceftriaxone
C) Tinidazole
D) Doxycycline
Answer: A
Explanation: A) Syphilis is treated with penicillin.
B) Gonorrhea is treated with ceftriaxone.
C) Trichomoniasis is treated with tinidazole or metronidazole.
D) Chlamydia is treated with doxycycline.
Page Ref: 2187
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 32.D. Analyze sexual violence as it relates to trauma. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual who has experienced sexual violence.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient dealing with sexual violence.

8) A victim of sexual assault has contracted trichomoniasis. Which prescription does the nurse anticipate for this client?
A) Penicillin
B) Ceftriaxone
C) Metronidazole
D) Doxycycline
Answer: C
Explanation: A) Syphilis is treated with penicillin.
B) Gonorrhea is treated with a combination of ceftriaxone.
C) Trichomoniasis is treated with metronidazole or tinidazole.
D) Chlamydia is treated with doxycycline.
Page Ref: 2187
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 32.D. Analyze sexual violence as it relates to trauma. Summarize diagnostic tests and therapies used by interprofessional teams in the collaborative care of an individual who has experienced sexual violence.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient dealing with sexual violence.

9) An older male client with rectal bleeding reports being sexually assaulted by a caregiver at a skilled facility. Which intervention will the nurse need to include in this client's plan of care before discharge?
A) Help the client find a new long-term care facility.
B) Help the client create a post-discharge safety plan.
C) Help the client find a lawyer to sue the long-term care facility.
D) Help the client understand the warning signs of suicide.
Answer: B
Explanation: A) The nurse is not responsible for helping the client find a new long-term care facility, although the nurse may refer the client to someone who can help in this area.
B) Younger and older individuals who are living with a caregiver may need help creating a post-discharge safety plan after sexual assault, especially if the perpetrator was the caregiver. This would be an important intervention to include in this client's plan of care.
C) The nurse is not responsible for helping the client find a lawyer although the nurse may refer the client to someone who can help in this area.
D) The nurse should watch for warning signs of suicide and teach warning signs to family members, but helping the client understand warning signs of suicide could cause the client to avoid the warning signs if suicidal, which could cause harm to the client.
Page Ref: 2187
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Planning
Learning Outcome: 32.D. Analyze sexual violence as it relates to trauma. Differentiate care of patients across the lifespan with a history of sexual violence.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient dealing with sexual violence.

10) The nurse is preparing to teach a class about date sexual assault to a group of college-age students. When discussing drug-facilitated sexual assault, which method of prevention should the nurse include in the presentation?
A) Never leave a location with a friend.
B) Only accept premade drinks from someone you know.
C) Never leave your drink unattended.
D) Only consume drinks handed to you directly by the bartender or a waitress.
Answer: C
Explanation: A) Individuals may leave a location with a friend that they explicitly trust even if they feel they have been drugged.
B) Individuals are often given date rape drugs by acquaintances, so accepting premade drinks even from an acquaintance may not be safe.
C) The nurse should include several methods of prevention in the presentation, including the instruction to never leave a drink unattended.
D) Individuals should watch their drink being made by the bartender rather than trusting that all drinks coming directly from a bartender or waitress are safe.
Page Ref: 2185
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Planning
Learning Outcome: 32.D. Analyze sexual violence as it relates to trauma. Differentiate care of patients across the lifespan with a history of sexual violence.
MNL LO: Demonstrate understanding of the concept of trauma in the care of the patient dealing with sexual violence.

The Concept of Reproduction

1) The nurse is providing care to a pregnant client who will undergo chorionic villus sampling. The client is currently 10 weeks pregnant. When teaching the client about this genetic testing, which layer of the embryonic membrane will the nurse say is tested during this procedure?
A) Chorion
B) Amnion
C) Ectoderm
D) Endometrium
Answer: A
Explanation: A) The chorion is the outermost embryonic membrane and develops into chorionic villi, which can be used for early genetic testing of the embryo at 10 to 11 weeks' gestation by chorionic villus sampling.
B) The amnion will develop into amniotic fluid, which can also be sampled for genetic testing but may not be developed by 10 weeks' gestation.
C) The ectoderm is a germ layer and will develop into specific structures within the developing fetus.
D) The endometrium is the lining of the uterus and will not be used for genetic testing of the embryo.
Page Ref: 2270
Cognitive Level: Remembering
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 33.2. Explain the processes of conception and embryonic development.
MNL LO: Analyze the concept of reproduction and its application to nursing care.

2) The nurse is caring for a client who is at 10 weeks' gestation. For which reason should the nurse instruct the client to avoid substance use during pregnancy?
A) Interferes with hormone excretion of the fetus
B) Facilitates the transfer of viruses and other diseases into the developing fetus
C) Passes into the developing fetus through the placenta very easily
D) Stops the synthesis of protein in the developing fetus
Answer: C
Explanation: A) Substances of abuse do not interfere with hormone excretion of the fetus.
B) They do not facilitate the transfer of viruses and other diseases into the developing fetus.
C) Substances of abuse pass from the mother to the fetus through the placenta via simple diffusion. These substances have adverse effects on the developing fetus.
D) Substances of abuse do not stop the synthesis of protein in the fetus.
Page Ref: 2211
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 33.2. Explain the processes of conception and embryonic development.
MNL LO: Analyze the concept of reproduction and its application to nursing care.

3) A client pregnant with a first child feels that the partner does not want the baby because of a renewed interest in playing tennis and visiting with college friends after work. When responding to the client, which should the nurse take into consideration?
A) This is a normal reaction by fathers that is seen in the second trimester of pregnancy.
B) This is a normal reaction by fathers that is seen in the third trimester of pregnancy.
C) This is a normal reaction by fathers that is seen in the first trimester of pregnancy.
D) This is an atypical reaction of the father to pregnancy that should be further examined.
Answer: A
Explanation: A) Pregnancy produces psychological changes in the mother and father of the child. A reaction seen in the father during the second trimester of pregnancy is a renewed interest in hobbies or activities outside of the family and is usually a sign of stress.
B) This behavior is not typical in the third trimester.
C) This behavior is not typical in the first trimester.
D) This behavior is not an atypical reaction that should be further examined.
Page Ref: 2224
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.4. Analyze the physical and psychological changes of pregnancy.
MNL LO: Analyze the concept of reproduction and its application to nursing care.

4) A pregnant adolescent client asks for information about the pregnancy and the baby because of the inability to afford prenatal care. Which action by the nurse is the most appropriate?
A) Provide the client with information on resources to assist with medical care during the pregnancy and after delivery.
B) Instruct the client on aspects of pregnancy, fetal development, and labor and delivery.
C) Ask the client if her parents are aware that she is pregnant and if she is covered by their medical insurance.
D) Tell the client that the father of the baby is responsible to pay for medical care for her during the pregnancy and after delivery.
Answer: A
Explanation: A) Poverty and low education levels are associated with adolescent pregnancy. The nurse should support the client by providing information on resources to assist with medical care during the pregnancy and after delivery.
B) The nurse should not instruct the client on all aspects of the pregnancy, including fetal development, labor, and delivery, as this can be overwhelming to the client.
C) The nurse should not ask the client if the parents are aware of the pregnancy.
D) The nurse should not tell the client that the baby's father is responsible for her medical care; these actions do not address the client's needs.
Page Ref: 2250
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 33.9. Differentiate considerations related to the care of patients with alterations in reproduction throughout the lifespan.
MNL LO: Analyze the concept of reproduction and its application to nursing care.

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5) An adolescent client at 34 weeks' gestation states to the nurse, "I am stressed out about becoming a mother. I hope that I can get back to my normal day-to-day activities after the baby is born, like hanging out with friends and studying." If the nurse wants to assess whether the client is performing normal developmental tasks for this stage of pregnancy, which question by the nurse is the most appropriate?
A) "Are your friends excited about the baby coming and planning a shower for you?"
B) "Are you prepared to delay some of your own needs and desires for your baby?"
C) "Do you miss going out with your friends on the weekends?"
D) "Have you been able to get enough rest while keeping up with your studies?"
Answer: B
Explanation: A) The nurse should not focus on the client's social activities as this is not a developmental task associated with pregnancy.
B) One developmental task for the mother is learning to give of oneself on behalf of the child. The statement by this client that she wants to get back to her normal activities indicates that she is still self-focused. The nurse should assess the client's preparedness for putting aside her own wants and needs temporarily for the good of her child.
C) The nurse should not focus on the client's social life and friends because these are not developmental tasks associated with the pregnancy.
D) Asking about rest and studying is not a developmental task associated with pregnancy.
Page Ref: 2223, 2250
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 33.4. Analyze the physical and psychological changes of pregnancy.
MNL LO: Analyze the concept of reproduction and its application to nursing care.

6) A client who says she is "about 6 weeks pregnant" hears the baby's heartbeat for the first time through a Doppler. Based on this data, which conclusion by the nurse is the most appropriate?
A) The mother is at 10 to 12 weeks' gestation.
B) The mother is over 16 weeks' gestation.
C) The mother is at 4 to 8 weeks' gestation.
D) The mother is at least 20 weeks' gestation.
Answer: A
Explanation: A) The ultrasonic Doppler device is the primary tool for assessing fetal heartbeat. It can detect fetal heartbeat, on average, at 10 to 12 weeks' gestation.
B) If an ultrasonic Doppler is not available, a fetoscope may be used. The fetal heartbeat can be detected by fetoscope between weeks 17 and 20 of pregnancy.
C) The client is not at 4 to 8 weeks' gestation because the Doppler device detected fetal heartbeat.
D) The client will have likely already heard the heartbeat at least once before 20 weeks' gestation if her primary care provider has access to a Doppler device.
Page Ref: 2221
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 33.4. Analyze the physical and psychological changes of pregnancy.
MNL LO: Analyze the concept of reproduction and its application to nursing care.

7) The nurse is providing care to a client who is experiencing nausea and vomiting during the first trimester of pregnancy. Which actions by the nurse are appropriate based on this data? **Select all that apply.**
A) Notify the healthcare provider that the client is experiencing hyperemesis gravidarum.
B) Educate the client to notify the healthcare provider if she vomits once per day.
C) Suggest the client use acupressure to pressure points on the wrist.
D) Teach the client that ginger may relieve her symptoms.
E) Caution the client against using over-the-counter medications such as over-the-counter antihistamines.
Answer: C, D
Explanation: A) There is no evidence that the client is experiencing hyperemesis gravidarum.
B) The client should be taught to notify the healthcare provider if vomiting occurs more than once a day.
C) Nausea and vomiting is a common experience during the first trimester of pregnancy. Acupressure is a complementary therapy that the nurse can suggest to the client to relieve the symptoms.
D) Nausea and vomiting is a common experience during the first trimester of pregnancy. Ginger is a complementary therapy that the nurse can suggest to the client to relieve the symptoms.
E) Over-the-counter antihistamines are safe to use during pregnancy to decrease the occurrence of nausea and vomiting if recommended by the doctor.
Page Ref: 2248
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 33.9. Analyze independent interventions nurses can implement for patients with alterations in reproduction.
MNL LO: Analyze the concept of reproduction and its application to nursing care.

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8) A client who is in the first trimester of pregnancy tells the nurse that she is constantly nauseated and can vomit at any time. To assist this client, the nurse should instruct her to do which of the following?

A) Drink a glass of water every time nausea occurs.

B) Take a multivitamin each day.

C) Take an over-the-counter antihistamine for the nausea.

D) Eat a snack any time nausea occurs.

Answer: B

Explanation: A) The nurse should not instruct the client to drink a glass of water every time nausea occurs because this could lead to the ingestion of high quantities of water.

B) Multivitamins may reduce the nausea associated with the first trimester of pregnancy.

C) The nurse should not instruct the client to ingest an over-the-counter medication without discussing this with her physician.

D) The nurse should not instruct the client to eat a snack any time nausea occurs, as this could lead to higher than needed calorie intake and inappropriate weight gain, and it also will not likely help the nausea significantly.

Page Ref: 2248

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 33.9. Analyze independent interventions nurses can implement for patients with alterations in reproduction.

MNL LO: Analyze the concept of reproduction and its application to nursing care.

9) A pregnant client in the second trimester has a hemoglobin of 10 g/dL. The client confirms fatigue, but otherwise feels fine. Which action by the nurse is the priority when providing care to this client?
A) Tell the client to rest when fatigue occurs.
B) Recommend the client add supplemental iron to the diet.
C) Ask the client to return in 2 months for a repeat check of the hemoglobin.
D) Order a screening for sickle cell anemia.
Answer: B
Explanation: A) Although adequate rest is important, it does not address the client's physiologic iron deficiency that is causing the fatigue.
B) Iron deficiency anemia is the most common medical complication of pregnancy; thus, low hemoglobin during pregnancy suggests an inadequate intake of dietary iron as the probable cause of her anemia. Given that the client's anemia is likely from iron deficiency, the nurse needs to emphasize the importance of increased iron supplementation.
C) The client should return in 1 month for a recheck of the hemoglobin levels; if improvement is not seen, then further evaluation is indicated.
D) A screening for sickle cell anemia is not indicated given the information presented.
Page Ref: 2254
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 33.8. Differentiate among common assessment procedures and tests used to examine reproduction.
MNL LO: Analyze the concept of reproduction and its application to nursing care.

10) The nurse is providing care to a client whose last menstrual period was 6 weeks ago. The client believes she is pregnant. Which diagnostic test does the nurse anticipate in order to confirm the pregnancy?
A) Serum or urine human chorionic gonadotropin (hCG)
B) Fetal heartbeat by Doppler
C) Fetal heartbeat by fetoscope
D) Fetal movement
Answer: A
Explanation: A) The most commonly used assay for pregnancy diagnosis is measuring the beta subunit of hCG in either urine or serum. hCG is detectable in more than 97% of clients.
B) A fetal heartbeat is diagnostic for pregnancy and is detectable by Doppler around the 10th to 12th week of gestation.
C) A fetal heartbeat is diagnostic for pregnancy and is detectable by fetoscope at about the 17th to 20th week.
D) Fetal movement, another objective sign of pregnancy, is palpable around 20 weeks' gestation by a trained examiner; pregnant women may experience movement subjectively, called quickening, around this same time.
Page Ref: 2221
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 33.4. Analyze the physical and psychological changes of pregnancy.
MNL LO: Analyze the concept of reproduction and its application to nursing care.

11) The partner of a pregnant client does not want to be a father and is upset that the client is pregnant. Which response by the nurse is appropriate?
A) "Do you think the client got pregnant on purpose, without your consent?"
B) "Have you considered giving the baby up for adoption?"
C) "Tell me more about why you feel this way."
D) "Every partner has these feelings, and many times they never go away."
Answer: C
Explanation: A) The nurse should not suggest that the client became pregnant on purpose because neither of these statements supports the client or partner at this time.
B) The nurse should not suggest that the baby be given up for adoption because this does not support the client or partner at this time.
C) The nurse needs to include the care of the partner when providing care to a pregnant client. The partner is expressing uncertainty about abilities to be a father and regrets the pregnancy. The best response by the nurse is to explore the partner's feelings.
D) The nurse should not minimize the partner's feelings by stating every partner has these feelings.
Page Ref: 2224
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 33.4. Analyze the physical and psychological changes of pregnancy.
MNL LO: Analyze the concept of reproduction and its application to nursing care.

12) The nurse is reviewing the immunization record for a client who just learned of being pregnant. Which vaccine should the nurse counsel the client to avoid?
A) Pertussis
B) Annual influenza
C) Rubella
D) Tetanus
Answer: C
Explanation: A) Pertussis vaccineS can safely be given in pregnancy.
B) The annual influenza vaccine can safely be given in pregnancy.
C) Rubella vaccine should never be given to pregnant clients because the vaccine contains the attenuated live virus, which has teratogenic effects on the developing fetus.
D) The tetanus vaccines can safely be given in pregnancy.
Page Ref: 2231
Cognitive Level: Remembering
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 33.7. Explain the promotion of healthy reproduction.
MNL LO: Analyze the concept of reproduction and its application to nursing care.

13) During which phase of the ovulatory cycle does the ovum get fertilized?
A) Follicular phase
B) Luteal phase
C) Proliferative phase
D) Secretory phase
Answer: B
Explanation: A) The ovum is still encapsulated in the graafian follicle in the follicular phase, and it cannot be penetrated by sperm.
B) The ovum can be fertilized as it moves through the fallopian tube, which occurs after the graafian follicle ruptures. The rupture of the graafian follicle begins the luteal phase.
C) The proliferative phase is a phase of the menstrual cycle.
D) The secretory phase is a phase of the menstrual cycle.
Page Ref: 2203
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.1. Analyze the physiology of the reproductive system.
MNL LO: Analyze the concept of reproduction and its application to nursing care.

Exemplar 33.A Antepartum Care

1) A client who recently learned of being pregnant reports not eating meat for several years and eating fish daily because it is healthier. Which teaching points are appropriate for this client based on the current diet? **Select all that apply.**
A) Avoid shrimp, salmon, and catfish because these have higher mercury levels.
B) Eat up to 12 ounces a week of a variety of fish and shellfish.
C) Do not eat more than 6 ounces per week of albacore tuna.
D) Eat plenty of fish such as king mackerel while pregnant.
E) Follow a complete vegetarian diet while pregnant as an alternative to eating fish.
Answer: B, C
Explanation: A) The nurse should encourage the client to consume shrimp, salmon, and catfish, because these fish have the least amount of mercury.
B) The nurse should instruct the client to eat up to 12 ounces a week of a variety of fish and shellfish.
C) The nurse should advise the client to eat no more than 6 ounces of albacore tuna each week because it has more mercury than other canned tuna.
D) King mackerel should be avoided because it contains high levels of mercury.
E) The nurse should not suggest that the client consume a complete vegetarian diet because this could lead to other nutritional deficiencies.
Page Ref: 2275
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 33.A. Summarize antepartum care of the pregnant woman. Describe factors that influence maternal nutrition and weight gain.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during antepartum.

2) A client at 16 weeks' gestation is diagnosed with tuberculosis (TB). Which statement by the nurse is appropriate when instructing the client regarding the needs for both the client and fetus?

A) "You have been prescribed isoniazid; therefore, you must also take pyridoxine (vitamin B_6)."

B) "Your contact with the baby will be limited for several months after delivery."

C) "You will not be able to breastfeed your baby because of this diagnosis."

D) "You are free to have contact with anyone as TB is not contagious when diagnosed during pregnancy."

Answer: A

Explanation: A) When teaching a pregnant client diagnosed with TB, the nurse will include information regarding medication administration. Isoniazid, which does cross the placenta but most studies show is not teratogenic, is often the drug of choice to treat TB during pregnancy. When taking isoniazid, the client will also need to take pyridoxine.

B) If TB is active at delivery, the newborn should not have direct contact with the mother while she is infectious. This is not likely going to be the case, as the client is diagnosed early in the pregnancy.

C) If maternal TB is inactive, the mother may breastfeed and care for the infant.

D) Extra rest and limited contact with others are required until the disease becomes inactive.

Page Ref: 2257

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 33.A. Summarize antepartum care of the pregnant woman. Describe commonly occurring alterations related to pregnancy.

MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during antepartum.

3) A client at 12 weeks' gestation reports nausea, breast tenderness, and fatigue. Which problem is a priority when the client's partner is tired of the constant complaining?
A) Ready to learn about parenting and newborn care.
B) Lack of knowledge about how to prepare for the childbirth process
C) Lack of knowledge of physiologic and psychologic processes of pregnancy
D) Potential for fluid volume deficiency if woman experiences vomiting or hyperemesis gravidarum
Answer: C
Explanation: A) There is no evidence that the client or partner are ready to learn about parenting and newborn care.
B) There is no evidence that the client lacks knowledge about preparing for childbirth.
C) The partner is unaware of the physiologic changes occurring in the client during the pregnancy. A lack of knowledge about the symptoms the client is experiencing and why they are occurring would be the main problem for this couple.
D) There is no evidence that the client is experiencing hyperemesis gravidarum.
Page Ref: 2286
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 33.A. Summarize antepartum care of the pregnant woman. Illustrate the nursing process in providing culturally competent care to the pregnant woman and her family.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during antepartum.

4) While learning exercises to perform during pregnancy, a client reports hearing that the arms should not be raised over the head because of harming the baby. Which action should the nurse make?
A) Provide dietary instruction instead to ensure the client does not gain excessive weight.
B) Tell the client to just perform the exercises that don't require reaching over the head.
C) Provide alternative activities to do instead of exercise.
D) Assure the client that reaching over the head will not harm the baby.
Answer: D
Explanation: A) Dietary instruction during pregnancy is important to ensure a healthy weight gain for a healthy baby, not to ensure the client does not gain excessive weight because of lack of exercise.
B) Telling the client to avoid the exercises that require reaching over the head will not address the misconception that reaching over the head will harm the baby.
C) Providing activities to do instead of exercise will not address the misconception that reaching over the head will harm the baby.
D) The nurse should assure the client that this is not accurate.
Page Ref: 2287-2289
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 33.A. Summarize antepartum care of the pregnant woman. Summarize relief of the common discomforts of pregnancy.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during antepartum.

5) A pregnant client and partner are concerned about the need for an amniocentesis. Which statement indicates that teaching provided to the client and partner about the procedure was effective?

A) "The test has to be done before the 14th week of pregnancy."
B) "If the test determines our baby has Down syndrome, we will not need to take childbirth classes."
C) "It is not unusual for amniocentesis to misdiagnose a problem with the baby."
D) "The test is 99% accurate to diagnose genetic abnormalities."

Answer: D

Explanation: A) For couples having an amniocentesis, the first few months of pregnancy can be difficult because the test cannot be performed until the 14th week of pregnancy.
B) Childbirth classes are important in promoting adaptation to the event of childbirth for expectant couples of any age or situation.
C) An amniocentesis will not misdiagnose a problem.
D) The results of an amniocentesis are 99% accurate in diagnosing genetic abnormalities.

Page Ref: 2270
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 33.A. Summarize antepartum care of the pregnant woman. Compare diagnostic tests used to assess fetal well-being.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during antepartum.

6) The nurse is providing care to a pregnant client who is experiencing ptyalism. Which will the nurse include in the plan of care for this client?
A) Use a cool-mist vaporizer
B) Suck on hard candy
C) Avoid use of nasal sprays and decongestants
D) Use low-sodium antacids
Answer: B
Explanation: A) A cool-mist vaporizer helps for nasal stuffiness and nosebleed (epistaxis).
B) Ptyalism is excessive, often bitter salivation that can occur during pregnancy. Appropriate interventions for this client include using astringent mouthwashes, chewing gum, or sucking on hard candy.
C) Using nasal sprays and decongestants are appropriate interventions for nasal stuffiness and nosebleed (epistaxis).
D) The use of low-sodium antacids is appropriate for pyrosis, or heartburn.
Page Ref: 2253
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 33.A. Summarize antepartum care of the pregnant woman. Summarize relief of the common discomforts of pregnancy.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during antepartum.

7) The nurse is teaching childbirth exercises to a pregnant client with a history of back pain. Which instruction is most appropriate for this client?
A) Perform the pelvic rock exercise only in the standing position.
B) Exercise in the supine position throughout the pregnancy.
C) Perform the pelvic rock exercise while in the hands and knees position.
D) Soak in a hot tub for approximately 30 minutes after exercise.
Answer: A
Explanation: A) The pelvic tilt or pelvic rock exercise helps prevent or reduce back strain, as it strengthens the abdominal muscles. The client with a history of back pain should be instructed to perform the exercise in the standing position only.
B) Pregnant clients should be instructed to avoid exercising in the supine position after the first trimester because it could hinder uterine blood flow and harm the fetus.
C) Doing the exercise on the hands and knees may aggravate back strain and cause pain.
D) Pregnant clients should be instructed to avoid hot tubs because of the possible teratogenic effects of hyperthermia on the developing fetus.
Page Ref: 2288
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 33.A. Summarize antepartum care of the pregnant woman. Illustrate the nursing process in providing culturally competent care to the pregnant woman and her family.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during antepartum.

8) The nurse is providing care to a client with a history of rheumatoid arthritis (RA) who is 5 months pregnant. Which nursing actions are appropriate when providing care to this client?
Select all that apply.
A) Telling the client there is an increased risk for preterm delivery because of salicylate therapy
B) Monitoring the client for anemia due to salicylate therapy
C) Suggesting the client begin supplemental pyridoxine
D) Educating the client that medication therapy may be discontinued due to remission
E) Teaching the client that RA may be contracted by the fetus during pregnancy
Answer: B, D
Explanation: A) Salicylate therapy is associated with prolonged gestation and labor.
B) When providing care to a client with RA during pregnancy, the nurse will monitor the client for anemia due to salicylate therapy.
C) Supplemental pyridoxine is required for clients being treated with isoniazid for TB during pregnancy.
D) Educate the client that medication therapy may be discontinued if the client experiences remission during the pregnancy.
E) RA cannot be contracted by the fetus during pregnancy.
Page Ref: 2256
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 33.A. Summarize antepartum care of the pregnant woman. Describe commonly occurring alterations related to pregnancy.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during antepartum.

9) The nurse is caring for a pregnant client who has asthma. The client has a cold and has an exacerbation of asthma symptoms, including mild wheezing. To help avoid hypoxia-related complications in the fetus, which medication prescription does the nurse anticipate?
A) IV corticosteroid (e.g., prednisone)
B) Oral pseudoephedrine (e.g., Sudafed)
C) Inhaled beta2-agonist (e.g., albuterol)
D) Oral acetylsalicylic acid (e.g., aspirin)
Answer: C
Explanation: A) Steroids should be avoided in pregnancy because of potential harmful effects to the fetus.
B) Decongestants such as pseudoephedrine should be avoided in pregnancy because of potential harmful effects to the fetus.
C) Albuterol, a beta2-agonist, is the medication recommended to treat asthma exacerbations during pregnancy.
D) Aspirin should be avoided in pregnancy because of potential harmful effects to the fetus.
Page Ref: 2255
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 33.A. Summarize antepartum care of the pregnant woman. Describe commonly occurring alterations related to pregnancy.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during antepartum.

10) Which pregnant client would have the greatest need for a nutritional assessment and individualized meal plan?
A) A client who is lactose intolerant
B) A client who is vegetarian
C) A client who requires a Kosher diet
D) A client with anorexia nervosa
Answer: D
Explanation: A) The client with lactose intolerance can learn alternatives to ensure adequate nutrition.
B) The client who follows a vegetarian eating plan can learn alternatives to ensure adequate nutrition.
C) The client who follows a Kosher diet can learn alternatives to ensure adequate nutrition.
D) The client with anorexia nervosa, an eating disorder, is at highest risk for inadequate nutrition. When a pregnant woman has an eating disorder, education and individualized meal plans can help the patient increase her dietary intake while maintaining a sense of control.
Page Ref: 2273
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 33.A. Summarize antepartum care of the pregnant woman. Describe factors that influence maternal nutrition and weight gain.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during antepartum.

11) The nurse is caring for a 14-year-old client who is pregnant. Which information will the nurse need to consider that may affect this client more than older adolescents?
A) The client may be more concerned about modesty.
B) The client may be more concerned with state marriage laws.
C) The client may be more concerned about parents finding out about the pregnancy.
D) The client may be more concerned about finding a support person.
Answer: A
Explanation: A) A younger client may be more concerned about modesty than older clients, especially as her body changes and grows rapidly.
B) Older adolescents who are pregnant may be more concerned about state marriage laws.
C) Older adolescents who are pregnant may be more concerned about parents finding out about the pregnancy.
D) Older adolescents who are pregnant may be more concerned about finding a support person.
Page Ref: 2278
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 33.A. Summarize antepartum care of the pregnant woman. Differentiate considerations related to the assessment and care of pregnant adolescents and women over 35.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during antepartum.

12) The nurse is caring for a 36-year-old pregnant woman. She has two children, ages 15 and 13, from a previous marriage, and this is her first child from her second marriage. The client has indicated that her two older children seem very upset by her pregnancy and have been increasingly belligerent the closer she gets to delivery. Which response can the nurse say to support this family?
A) "It may help to remind your older children that you will still make time for them and that you won't expect them be responsible for the baby unless they want to."
B) "You could tell your older children that the stress and anxiety that comes with a new baby will help improve your family relationships."
C) "They are probably just embarrassed because you are pregnant. They'll get over it once you have the baby."
D) "Your older children probably just want to know what their new roles will be once the baby is born. You should tell them what their responsibilities will be in caring for the baby."
Answer: A
Explanation: A) Adolescent children, especially children from a previous marriage, may feel jealous that the new baby will take all the attention of the parent or fear that they will be asked to contribute to the newborn's care. The nurse should help the mother understand these feelings and encourage the mother to address these feelings with her older children.
B) Discussing the role of stress and anxiety in improving relationships is more appropriate for a spouse, not older children.
C) Telling the mother that the older children are just embarrassed and will get over it is inappropriate.
D) Encouraging the mother to give newborn care responsibilities to the older children may make the issue worse.

Page Ref: 2279
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 33.A. Summarize antepartum care of the pregnant woman. Differentiate considerations related to the assessment and care of pregnant adolescents and women over 35.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during antepartum.

Exemplar 33.B Intrapartum Care

1) The nulliparous client states, "I have been in labor for 4 hours and I am still only 2 cm dilated. Why is this happening? I feel like I should be ready to push by now." Which is the best response by the nurse?
A) "When your perineal body thins out, your cervix will begin to dilate much faster than it is now."
B) "The hormones that cause labor to begin are just getting to the levels that will change your cervix."
C) "What did you expect? You've only had contractions for a few hours. Labor takes time."
D) "Your cervix has also effaced, or thinned out, and that change in the cervix is also labor progress."
Answer: D
Explanation: A) The perineal body thinning primarily occurs during the second stage of labor; it is not expected early in labor.
B) The hormones that cause labor contractions do not directly cause cervical change; the contractions cause the cervix to change.
C) The reply "what did you expect" is not therapeutic. Although it is true that this client has only been in early labor for a short time, and it is true that labor for a nullipara averages 12-24 hours, the nurse must always be therapeutic in all communication.
D) Cervical effacement must be nearly complete before cervical dilation takes place in primiparas. This is why the labor and birth of a first baby usually take much more time than for subsequent labor and births.
Page Ref: 2299

Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 33.B.2. Summarize intrapartum care of the pregnant woman. Describe the physiology of labor.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during intrapartum.

2) During the fourth stage of labor, a client's blood pressure is 110/60 mmHg, pulse 90, and the fundus is firm, midline, and halfway between the symphysis pubis and the umbilicus. Based on this data, which action should the nurse take?
A) Massage the fundus.
B) Turn the client onto the left side.
C) Place the bed in the Trendelenburg position.
D) Continue to monitor.
Answer: D
Explanation: A) The uterus should be midline and firm; massage is not necessary.
B) A left lateral position is not necessary with a BP of 110/60 and a pulse of 90.
C) The Trendelenburg position is not necessary with a BP of 110/60 and a pulse of 90.
D) The client's assessment data are normal for the fourth stage of labor, so monitoring is the only action necessary. During the fourth stage of labor, the mother experiences a slight drop in blood pressure and a slightly increased pulse.
Page Ref: 2306
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 33.B. Summarize intrapartum care of the pregnant woman. Outline the stages of labor and birth.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during intrapartum.

3) The nurse is instructing a pregnant client on how the baby's condition is evaluated during labor. Which client statement indicates appropriate understanding of the information presented?
A) "During labor, the nurse will verify that my contractions are strong but not too close together."
B) "During labor, the nurse will look at the color and amount of bloody show that I have."
C) "During labor, the nurse will assess the baby's heart rate with a Doppler ultrasound."
D) "During labor, the nurse will regularly check my cervix by doing a pelvic exam."
Answer: C
Explanation: A) The nurse will monitor contractions, but this does not monitor the baby's condition.
B) The nurse will also monitor for a bloody show, but this will not monitor the baby's condition.
C) During labor, the nurse will assess the baby's heart rate with a Doppler ultrasound unless complications are present. This is the statement the client should make to prove that education was successful.
D) The nurse will also monitor the cervix, but this will not monitor the baby's condition.
Page Ref: 2328
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 33.B. Summarize intrapartum care of the pregnant woman. Illustrate the nursing process in providing culturally competent care to the pregnant woman and her family.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during intrapartum.

4) A client in the fourth stage of labor is experiencing perineal trauma. Which problem is the priority at this time?
A) Family coping
B) Fear
C) Anxiety
D) Pain
Answer: D
Explanation: A) Family coping is not a problem for the client during this stage of labor.
B) The client's priority is not fear during this stage of labor.
C) Anxiety is not the problem during this stage of labor.
D) Many clients experience perineal trauma during the childbirth process, which causes pain in the fourth stage of labor. This is the priority problem for this client.
Page Ref: 2336
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 33.B. Summarize intrapartum care of the pregnant woman. Illustrate the nursing process in providing culturally competent care to the pregnant woman and her family.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during intrapartum.

5) The nurse is providing care to the client during the second stage of labor. Which nursing action is appropriate?
A) Assessing maternal temperature every 1-2 hours after amniotic membranes have ruptured
B) Encouraging the client to void every 1-2 hours
C) Assessing fetal heart rate every 5 minutes
D) Administering antibiotics for a positive group beta strep
Answer: C
Explanation: A) Assessing temperature every 1 to 2 hours after amniotic membranes have ruptured is appropriate during the first stage of labor.
B) Encouraging the client to void is appropriate during the first stage of labor.
C) The second stage of labor is reached when the cervix is completely dilated. At this time, it is appropriate for the nurse to assess fetal heart rate every 5 minutes or after every contraction.
D) Administering antibiotics is appropriate during the first stage of labor.
Page Ref: 2344
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 33.B. Summarize intrapartum care of the pregnant woman. Illustrate the nursing process in providing culturally competent care to the pregnant woman and her family.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during intrapartum.

6) The nurse is providing care to a client in labor who experiences spontaneous rupture of membranes. The fetus is in the vertex position. The nurse notes that the amniotic fluid is meconium stained. Based on this data, which action should the nurse make a priority?
A) Notifying the healthcare provider that birth is imminent
B) Changing the client's position in bed
C) Beginning continuous fetal heart rate monitoring
D) Administering oxygen at 2 liters per minute
Answer: C
Explanation: A) Meconium-stained amniotic fluid does not indicate that birth is imminent.
B) Changing the client's position is not indicated.
C) Meconium-stained amniotic fluid is an abnormal fetal finding and is an indication for continuous fetal monitoring.
D) Oxygen administration is not indicated.
Page Ref: 2329
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 33.B. Summarize intrapartum care of the pregnant woman. Illustrate the nursing process in providing culturally competent care to the pregnant woman and her family.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during intrapartum.

7) The laboring client's fetal heart rate baseline is 120 beats per minute (bpm). Accelerations are present to 135 bpm. During contractions, the fetal heart rate gradually slows to 110 bpm and is at 120 bpm by the end of the contraction. Which nursing action is appropriate?
A) Documenting the fetal heart rate
B) Preparing for imminent delivery
C) Applying oxygen via mask at 10 liters per minute
D) Assisting the client into the Fowler position
Answer: A
Explanation: A) The described fetal heart rate has a normal baseline, the presence of accelerations indicates adequate fetal oxygenation, and early decelerations are normal. No intervention is necessary.
B) There is no indication that delivery will be occurring soon.
C) The fetal heart rate tracing is normal; oxygen is not indicated.
D) The client does not need to be assisted into the Fowler position.
Page Ref: 2333
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 33.B. Summarize intrapartum care of the pregnant woman. Summarize the maternal and fetal response to labor.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during intrapartum.

8) A pregnant client presents to the emergency department reporting that she has started labor and is certain the baby is coming "any minute now." After assessing and monitoring the client, the healthcare team determines that the client is in "false" labor, and the nurse prepares her for discharge. Which observations support the conclusion of false labor? **Select all that apply.**
A) The contractions do not have a regular pattern.
B) Cervix has dilated 2 cm over the 2 hours of observation.
C) The frequency and intensity of the contractions have stayed about the same.
D) Walking seems to increase the strength of the contractions.
E) The contractions are mostly in her abdomen.
Answer: A, C, E
Explanation: A) Signs and symptoms of "false" labor, in contrast to "true" labor, include a pattern of irregular contractions.
B) Cervical dilation is an indication of true labor.
C) Signs and symptoms of "false" labor, in contrast to "true" labor, include contractions that do not increase in frequency or intensity.
D) A change in activity that increases the strength of contractions indicates true labor.
E) Signs and symptoms of "false" labor include discomfort that is felt mostly in the abdomen rather than in the back.
Page Ref: 2301
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 33.B. Summarize intrapartum care of the pregnant woman. Summarize factors important to labor and birth.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during intrapartum.

9) During an assessment, the nurse notes the client in the fourth stage of labor is experiencing intense shaking and chills. Based on this data, which conclusion by the nurse is appropriate?
A) This is evidence of incomplete expulsion of the placenta.
B) The client has a full bladder.
C) This is a normal reaction to the ending of the physical exertion of labor.
D) The client has a fever from a postpartum infection.
Answer: C
Explanation: A) Shaking and chills after delivery is not evidence of incomplete expulsion of the placenta.
B) Indications of a full bladder would most likely be a displaced uterus.
C) Many clients experience a shaking chill in the fourth stage of labor, which is thought to be associated with the ending of the physical exertion of labor.
D) The nurse would need to assess the client's temperature to determine the presence of a fever.
Page Ref: 2306
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.B. Summarize intrapartum care of the pregnant woman. Outline the stages of labor and birth.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during intrapartum.

10) A pregnant woman at 41 weeks' gestation has a Bishop score of 5. Which conclusion should the nurse make from this score?
A) The cervix is favorable for a normal vaginal delivery.
B) The cervix is unfavorable, and induction of labor may be necessary.
C) The cervix is unfavorable, and a cesarean section may be necessary.
D) The cervix is favorable, and labor has been successfully induced.
Answer: B
Explanation: A) A Bishop score less than 6 indicates that the cervix is unfavorable for a normal vaginal delivery.
B) A Bishop score less than 6 indicates that the cervix is unfavorable. When a pregnant woman at or near term has an unfavorable cervix, induction of labor may be necessary for medical or obstetric reasons.
C) A Bishop score less than 6 does not indicate that a cesarean section may be necessary.
D) A Bishop score less than 6 indicates that the cervix is unfavorable, and labor has not been induced.
Page Ref: 2308
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.A. Summarize intrapartum care of the pregnant woman. Describe maternal and fetal alterations during the intrapartum period.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during intrapartum.

11) The nurse is caring for a 15-year-old pregnant adolescent during the labor and delivery process. The client has no support person with her, and she plans to give up her baby for adoption. Which intervention should the nurse implement to facilitate the grieving process for this client?
A) Encourage the client to avoid seeing and holding the baby.
B) Encourage the client to see and hold the baby.
C) Encourage the client to have the adoptive parents present for the birth.
D) Encourage the client to sign the adoption papers as soon as possible after the birth.
Answer: B
Explanation: A) The nurse should not discourage the adolescent from seeing her baby.
B) The adolescent who is planning to give up her baby for adoption should be given the option of seeing and holding her baby. This facilitates the grieving process. However, seeing or holding the newborn should be her choice.
C) Because of privacy concerns, the nurse should not encourage the adolescent to have the adoptive parents present for the birth except for special circumstances as determined by the client, not the nurse.
D) The nurse should not encourage the adolescent to sign adoption papers as soon as possible after the birth.
Page Ref: 2371
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 33.B. Summarize intrapartum care of the pregnant woman. Differentiate considerations related to the assessment and care of pregnant adolescents and women over 35.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during intrapartum.

12) The nurse is planning for several clients who are pregnant for the first time who are in the labor and delivery process. Which client has the highest risk of labor and delivery complications?

A) A healthy 38-year-old client
B) A 24-year-old client with asthma
C) A 36-year-old client with diabetes
D) A 31-year-old client with anemia

Answer: C

Explanation: A) Risks are much lower for clients over the age of 35 who do not have preexisting medication conditions.
B) Risks are much lower for clients under the age of 35.
C) Clients over the age of 35 have an increased risk for complications during labor and delivery, especially when the client already has preexisting medical conditions such as diabetes.
D) Risks are much lower for clients under the age of 35.

Page Ref: 2320
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.B. Summarize intrapartum care of the pregnant woman. Differentiate considerations related to the assessment and care of pregnant adolescents and women over 35.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during intrapartum.

Exemplar 33.C Postpartum Care

1) During a postpartum examination of a client who delivered an 8-pound newborn 6 hours ago, the nurse assesses the following: fundus firm and at the umbilicus, and moderate lochia rubra with a steady trickle of blood noted from the vagina. Which assessment finding requires immediate follow-up?
A) Moderate lochia rubra
B) Steady trickle of blood
C) Fundus at the umbilical level
D) Firm fundus
Answer: B
Explanation: A) Moderate lochia rubra is considered a normal finding.
B) The steady trickle of blood could indicate a laceration in the birth canal and should be reported to the healthcare provider for follow-up.
C) Six hours after birth, the fundus at the umbilicus would not be a concern.
D) A firm fundus is a desired finding and is considered normal.
Page Ref: 2352
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.C. Summarize postpartum care of the mother. Summarize physical adaptations of the body systems postpartum.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during postpartum.

2) The nurse is providing postpartum care to a client from a different culture. Which actions are appropriate to include in the client's plan of care? **Select all that apply.**
A) Assess for any assistance required during breastfeeding.
B) Ask if there are any specific customs the client wants to follow.
C) Assess for any specific foods or fluids to hasten recovery.
D) Limit client visitors to the immediate family.
E) Restrict interactions with the client.
Answer: A, B, C
Explanation: A) When providing postpartum care to a client of a different culture, the nurse should assess if the client requires any assistance during breastfeeding.
B) When providing postpartum care to a client of a different culture, the nurse should assess for any specific customs the client wants to follow.
C) When providing postpartum care to a client of a different culture, the nurse should assess if there are any foods or fluids in the culture that are believed to hasten recovery.
D) Restricting visitors would not support the postpartum client's needs.
E) Restricting interactions would not support the client's physiologic or psychologic needs.
Page Ref: 2363
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning
Learning Outcome: 33.C. Summarize postpartum care of the mother. Illustrate the nursing process in providing culturally competent care to the new mother and her family.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during postpartum.

3) A client who gave birth to her first child 12 hours ago has the following assessment findings: nausea for 2 hours; boggy fundus that firmed with massage; moderately heavy lochia rubra; ecchymotic and edematous perineum; and pain rating of 6 on a scale of 0-10. The client's partner is present and supportive. Breastfeeding has been successful three times. Based on this data, which problem is the priority?
A) Pain
B) Insufficient fluid intake
C) Anxiety related to role change
D) Readiness to learn about parenting and baby care
Answer: A
Explanation: A) The client has a pain level of 6, so treating pain is a high priority for this client.
B) Pain could contribute to nausea and a decreased desire to drink fluids, so treating the pain could decrease the insufficient fluid intake.
C) There is no evidence that the client has anxiety about role change.
D) There is no evidence that the client is ready to learn about parenting and baby care.
Page Ref: 2365
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 33.C. Summarize postpartum care of the mother. Illustrate the nursing process in providing culturally competent care to the new mother and her family.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during postpartum.

4) The nurse is planning care for a client who had a cesarean birth 4 hours ago. Which actions should be included in this client's plan of care? **Select all that apply.**

A) Encourage the use of breathing, relaxation, and distraction.
B) Encourage deep breathing and coughing every 2 to 4 hours.
C) Encourage to ambulate to the bathroom to void.
D) Discourage leg exercises.
E) Withhold all analgesics.

Answer: A, B

Explanation: A) Encouraging the use of breathing, relaxation, and distraction all address the client's nursing care needs, which are similar to those of other surgical clients.

B) Encouraging deep breathing and coughing every 2 to 4 hours addresses the client's nursing care needs, which are similar to those of other surgical clients.

C) Encouraging the client to ambulate to the bathroom to void might be an intervention done on the first or second day postpartum, but not in the first 4 hours.

D) Leg exercises should be encouraged.

E) Withholding analgesics may leave the client in pain.

Page Ref: 2371

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 33.C. Summarize postpartum care of the mother. Illustrate the nursing process in providing culturally competent care to the new mother and her family.

MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during postpartum.

5) A postpartum client is experiencing pain from an episiotomy. Which actions will the nurse suggest to the client to decrease discomfort? **Select all that apply.**

A) Washing the area with soap and water every day
B) Tightening the buttocks before sitting
C) Changing peripads daily
D) Performing leg scissor kicks several times a day
E) Increasing the intake of meat, cheese, fish, eggs, and nuts

Answer: B, E

Explanation: A) The client should wash the area daily however this will not reduce discomfort but will rather prevent infection.
B) The nurse should instruct the client to tighten the buttocks before sitting to reduce the pain.
C) The peripad should be changed four times a day to decrease the risk of infection, not pain.
D) Performing leg scissor kick exercises would put strain on the incision site and should not be done.
E) Lysine has been identified as an essential amino acid that decreases the pain of an episiotomy. This amino acid is present in meat, cheese, fish, eggs, and nuts.

Page Ref: 2367
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 33.C. Summarize postpartum care of the new mother. Illustrate the nursing process in providing culturally competent care to the new mother and her family.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during postpartum.

6) When palpating the fundus of a woman on her first day postpartum, the nurse finds that the woman's uterus is higher than expected and is deviated to the right. She is not having excessive uterine bleeding. Which action should the nurse take?
A) Notify the client's midwife of this condition.
B) Ask another nurse to assess the client to verify the findings.
C) Ask the client to void and then reassess fundal height.
D) Perform a straight catheterization on the client and then reassess fundal height.
Answer: C
Explanation: A) The nurse would not notify the client's midwife about the data unless the assessment remains unchanged after the client voids.
B) Asking another nurse to verify the assessment findings is not an appropriate action.
C) The cause of a distended fundus in a recently delivered woman is likely due to a distended bladder causing a temporary upward displacement of the uterus. Having the woman empty her bladder and then reassessing fundal height is the priority action for the nurse to take at this time.
D) If the client is unable to void, a straight catheterization to empty the bladder is indicated, after which fundal height would then be reassessed.
Page Ref: 2354
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 33.C. Summarize postpartum care of the new mother. Summarize physical adaptations of the body systems postpartum.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during postpartum.

7) Upon delivery of the newborn, which nursing intervention promotes parental attachment?
A) Placing the newborn under the radiant warmer
B) Placing the newborn on the bed next to the mother
C) Placing the newborn on the maternal chest
D) Taking the newborn to the nursery for the initial assessment
Answer: C
Explanation: A) Placing the baby under the radiant warmer does not promote attachment.
B) Placing the baby on the bed next to the mother does not promote maternal attachment.
C) Placing the baby on the maternal chest promotes attachment and bonding and gives the mother a chance to interact immediately with her baby.
D) Taking the newborn to the nursery for the initial assessment does not promote attachment.
Page Ref: 2368
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 33.C. Summarize postpartum care of the new mother. Illustrate the nursing process in providing culturally competent care to the new mother and her family.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during postpartum.

8) If a woman had a prepregnancy daily requirement of 1800 calories and she decides to breastfeed her newborn, how many calories should the nurse recommend the woman take in each day?
A) 2300 calories
B) 2500 calories
C) 2000 calories
D) 1800 calories
Answer: A
Explanation: A) The breastfeeding mother should take in 500 more calories than her prepregnancy requirements. Therefore, she should take in 2300 calories each day.
B) The breastfeeding mother should not ingest 700 more calories a day than her prepregnancy requirements.
C) The breastfeeding mother should take in more than 200 calories more than her prepregnancy requirements.
D) The woman who is not breastfeeding should return to her prepregnancy requirement of 1800 calories per day.
Page Ref: 2358
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 33.C. Summarize postpartum care of the new mother. Outline the nutrition requirements for new mothers.

MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during postpartum.

9) Before a first-time mother is discharged from the hospital with her newborn, the nurse notices that the mother is taking directions on newborn care from her parents and in-laws. Which stage of maternal role attainment is the new mother in?

A) Anticipatory stage

B) Formal stage

C) Informal stage

D) Personal stage

Answer: B

Explanation: A) The anticipatory stage occurs during pregnancy.

B) In the formal stage of maternal role attainment, the woman is influenced by the guidance of others and tries to act as she believes others expect her to act.

C) The informal stage occurs when the mother begins to make her own choices about mothering.

D) The personal stage occurs when the mother is comfortable with the notion of herself as "mother."

Page Ref: 2355

Cognitive Level: Understanding

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 33.C. Summarize postpartum care of the new mother. Describe the psychological adaptations of the mother postpartum.

MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during postpartum.

10) Which symptom would the nurse recognize as being consistent with postpartum endometritis at 4 weeks postpartum?
A) Foul-smelling lochia
B) Bright red lochia
C) Upper abdominal pain
D) Bradycardia
Answer: A
Explanation: A) Assessment findings consistent with endometritis are foul-smelling lochia, fever, cramping, abdominal pain, chills, malaise, and anorexia.
B) Bright red lochia might indicate postpartum hemorrhage at 4 weeks postpartum.
C) Upper abdominal pain is not associated with endometritis.
D) Bradycardia is not associated with endometritis.
Page Ref: 2360
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.C. Summarize postpartum care of the new mother. Summarize alterations in the postpartum period.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during postpartum.

11) A 16-year-old has just given birth, and she plans to keep and care for the baby. However, the nurse determines that the young mother has low self-esteem, and she does not appear to have adequate social support. The nurse should encourage adequate follow-up care for this young mother for which reason?
A) She is at risk for postpartum hemorrhage.
B) She is at risk for postpartum endometritis.
C) She is at risk for postpartum depression.
D) She is at risk for postpartum weight gain.
Answer: C
Explanation: A) Having low self-esteem and no social support does not increase the adolescent's risk for postpartum hemorrhage.
B) There is not enough information to determine if she is at risk for postpartum endometritis.
C) Young mothers with low self-esteem, family conflict, and few social supports are more likely to encounter postpartum depression. The nurse should carefully assess the young mother for risk factors and provide appropriate referrals for follow-up.
D) The client may be at higher risk for inadequate nutrition rather than excessive weight gain.
Page Ref: 2360
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Assessment

Learning Outcome: 33.C. Summarize postpartum care of the new mother. Differentiate considerations related to the assessment and care of pregnant adolescents and women over 35.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during postpartum.

12) The nurse is providing discharge instructions for a healthy 37-year-old first-time mother and her newborn. Which information should the nurse include in her instructions for this mother and her spouse?
A) Information related to contraception and sexually transmitted infections (STIs).
B) A reminder that addition of a newborn will alter established routines.
C) A referral to a group class that provides information on newborn care.
D) A referral for follow-up care with healthcare providers other than the obstetrician.
Answer: B
Explanation: A) Information related to contraception and STIs is more appropriate for adolescent mothers.
B) Women who are over 35 have life experiences and education that often better prepare them for parenthood. However, older couples must be made aware that the addition of a newborn will alter established routines and practices.
C) A referral to a group class on newborn care is more appropriate for adolescent mothers.
D) A referral for follow-up care with other healthcare providers is appropriate for women over 35 who have preexisting conditions or complications.
Page Ref: 2361
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 33.C. Summarize postpartum care of the new mother. Differentiate considerations related to the assessment and care of pregnant adolescents and women over 35.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the patient during postpartum.

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Exemplar 33.D Newborn Care

1) The nurse is providing care to a 1-hour-old newborn who was born at 39 weeks' gestation. Which assessment data is cause for concern? **Select all that apply.**
A) Respiratory rate of 82 breaths per minute
B) Negative Babinski reflex
C) Mean blood pressure of 52 mmHg
D) Acrocyanosis
E) Presence of musical heart murmur
Answer: A, B
Explanation: A) Assessment data that would cause this nurse concern include a respiratory rate of 82 breaths per minute. Respirations within 2 hours of delivery are expected to be between 60 and 70 breaths per minute. Anything above this is abnormal.
B) Assessment data that would cause this nurse concern include a negative Babinski reflex. A positive Babinski reflex is an expected finding. A negative Babinski could indicate neurologic compromise.
C) The nurse would expect a mean blood pressure of 52 mmHg (normal range is 31-61 mmHg).
D) The nurse would expect acrocyanosis.
E) A musical heart murmur is considered common.
Page Ref: 2386
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.D. Summarize care of newborns. Summarize the adaptations of the newborn to extrauterine life.
MNL LO: Demonstrate understanding of the concept of reproduction in the provision of newborn care.

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2) The nurse receives shift change report on infants born within the last 4 hours. Which newborn should the nurse assess first?
A) Newborn born at 37 weeks' gestation. Respiratory rate of 45 breaths per minute.
B) Term newborn, 2 hours old, who has not passed a meconium stool.
C) Term newborn born 3 hours ago. Heart rate is 150 beats per minute.
D) Term newborn born 1 hour ago who is exhibiting grunting respirations.
Answer: D
Explanation: A) A normal respiratory rate is 30-60 breaths per minute.
B) If a meconium stool is not passed within the first 24 hours, this would be cause for concern.
C) A normal pulse is 120-160 beats per minute.
D) Grunting respirations are an indication of respiratory distress. This infant needs further assessment and possibly immediate intervention.
Page Ref: 2416
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.D. Summarize care of newborns. Summarize the adaptations of the newborn to extrauterine life.
MNL LO: Demonstrate understanding of the concept of reproduction in the provision of newborn care.

3) A client delivers a newborn son and plans to breastfeed. When the nurse attempts to help the newborn latch on for breastfeeding, the client states, "I would like to bottle feed my baby for the first few days." Which reason might the nurse hear regarding why the client wants to delay breastfeeding?
A) Colostrum is bad for the baby.
B) The birthing process spoils breast milk.
C) It will cause "evil eye."
D) Female baby will be breastfed longer than a male baby.
Answer: A
Explanation: A) Some Asian, Haitian, Hispanic, Eastern European, and Native American cultures believe breastfeeding should be delayed because colostrum is bad for the baby.
B) A Haitian client may believe that strong emotions, not the birthing process, spoil breast milk.
C) Some Latin American cultures do not believe that breastfeeding causes evil eye but rather that touching the head or the face of the baby when admiring it will ward off the "evil eye."
D) Individuals of Iranian heritage may breastfeed female babies longer than male babies.
Page Ref: 2422
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 33.D. Summarize care of newborns. Illustrate the nursing process in providing culturally competent care to the newborn.
MNL LO: Demonstrate understanding of the concept of reproduction in the provision of newborn care.

4) The nurse is caring for a newborn boy who was circumcised an hour ago. Which problem is the priority for the newborn?
A) Pain
B) Risk for infection
C) Difficulty breastfeeding
D) Impaired airway clearance
Answer: B
Explanation: A) Pain is more likely due to procedures such as heel sticks and injections.
B) The client is at increased risk for infection because of the circumcision.
C) There is no evidence that the client is having difficulty breastfeeding.
D) There is no evidence that the client has impaired airway clearance.
Page Ref: 2413
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis
Learning Outcome: 33.D. Summarize care of newborns. Illustrate the nursing process in providing culturally competent care to the newborn.
MNL LO: Demonstrate understanding of the concept of reproduction in the provision of newborn care.

5) The nurse is caring for the 1-hour-old newborn of a mother with diabetes mellitus. Which actions will the nurse include in the newborn's plan of care? **Select all that apply.**

A) Assess blood glucose frequently.
B) Assess for SGA.
C) Assess for hyperthyroidism.
D) Assess the newborn's temperature hourly.
E) Assess for hyperbilirubinemia.

Answer: A, E

Explanation: A) In a newborn of a mother with diabetes, the onset of hypoglycemia occurs at 1-3 hours after birth and can continue for several days. Blood glucose levels should be checked frequently during the first several days.

B) Newborns of mothers with diabetes are often LGA (large for gestational age), not SGA (small for gestational age).

C) Alterations in thyroid hormone levels are not associated with newborns of mothers with diabetes.

D) Alterations in temperature are not associated with newborns of mothers with diabetes.

E) The nurse should assess lab results for hypocalcemia, hyperbilirubinemia, and polycythemia.

Page Ref: 2390
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 33.D. Summarize care of newborns. Outline alterations found in newborns.
MNL LO: Demonstrate understanding of the concept of reproduction in the provision of newborn care.

6) The nurse is instructing a new mother on how to care for the newborn's circumcision site. Which statements indicate that the nurse's education session was effective? **Select all that apply.**

A) "I should not use petroleum jelly on the penis."
B) "Every time I change the diaper, I am to wash the area with warm water."
C) "I should report any pus drainage or change in diaper wetness to the physician."
D) "Swelling is expected."
E) "I am to use soap and water to remove yellow tissue on the penis."

Answer: B, C

Explanation: A) The nurse should instruct the mother to use petroleum jelly to protect the penis and prevent bleeding.

B) The nurse should instruct the mother to wash the area with warm water after every diaper change.

C) The nurse should instruct the mother to report any pus drainage or change in urine output to the physician.

D) Swelling is not expected after a circumcision and should be reported to the physician.

E) Yellow tissue on the penis is granulation tissue, which is evidence of healing and should not be washed off with soap and water.

Page Ref: 2419

Cognitive Level: Analyzing

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation

Learning Outcome: 33.D. Summarize care of newborns. Illustrate the nursing process in providing culturally competent care to the newborn.

MNL LO: Demonstrate understanding of the concept of reproduction in the provision of newborn care.

7) When administering an intramuscular dose of vitamin K (phytonadione) to a newborn, which actions by the nurse are appropriate? **Select all that apply.**

A) Using a 23-gauge 1/2-inch needle
B) Cleaning the skin with an alcohol swab
C) Preparing 5 mg of the medication for injection
D) Using the middle third of the vastus lateralis muscle
E) Washing the skin with soap and water

Answer: B, D

Explanation: A) A 23-gauge 1/2-inch needle is not used. A 27-gauge 1/2-inch needle is used.
B) The nurse should clean the skin with an alcohol swab.
C) The medication dosage is between 0.5 and 1.0 mg.
D) The nurse should use the middle third of the vastus lateralis muscle.
E) The skin is not to be washed with soap and water before the injection.

Page Ref: 2396

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 33.D. Summarize care of newborns. Illustrate the nursing process in providing culturally competent care to the newborn.

MNL LO: Demonstrate understanding of the concept of reproduction in the provision of newborn care.

8) The nurse is providing discharge instructions for a first-time mother and her baby. Which statement is appropriate for the nurse to include in the teaching session?
A) "Your baby's stools will change to a dark green color when your milk comes in."
B) "Your baby may spit up frequently for the first few weeks."
C) "Compress the bulb syringe before placing it in your baby's nose or mouth."
D) "You can wipe away any green drainage that might form around the umbilical cord."
Answer: C
Explanation: A) Stool color is often seedy and yellow or golden brown in color when breastfeeding.
B) The baby may spit up frequently in the first day or two, but this should not continue for several weeks.
C) A bulb syringe is often used to suction excess secretions from the baby's nose and mouth. The bulb syringe should be compressed before placing it gently in the baby's nose or mouth.
D) Green drainage from the umbilical cord is abnormal and should be reported to the baby's provider.
Page Ref: 2423
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 33.D. Summarize care of newborns. Illustrate the nursing process in providing culturally competent care to the newborn.
MNL LO: Demonstrate understanding of the concept of reproduction in the provision of newborn care.

9) The nurse is providing care to a newborn during the first 24 hours of life. Which finding should the nurse report as unexpected?
A) Respiratory rate of 58 breaths per minute
B) Heart rate of 140 beats per minute
C) Presence of meconium stool
D) Yellowing of the skin
Answer: D
Explanation: A) A respiratory rate of 58 breaths per minute is an expected finding.
B) A heart rate of 140 beats per minute is an expected finding.
C) Meconium stool is an expected finding.
D) Yellowing of the skin within the first 24 hours of life is caused by pathologic jaundice and often requires treatment with phototherapy.
Page Ref: 2381
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.D. Summarize care of newborns. Summarize the adaptations of the newborn to extrauterine life.
MNL LO: Demonstrate understanding of the concept of reproduction in the provision of newborn care.

10) The nurse conducting a 5-minute Apgar assessment on a newborn assigns the following ratings: Heart rate <100 beats per minute (1 point); slow, irregular respirations (1 point); some flexion of the extremities (1 point); a vigorous cry with flicking of the baby's foot (2 points); and a pink body with blue extremities (1 point). Based on this data, which nursing action is appropriate?

A) Having unlicensed personnel reassess the newborn's heart rate and respiratory rate when admitted to the nursery

B) Swaddling the newborn to decrease the risk of increased energy expenditure

C) Placing the newborn in the mother's arms and asking her to monitor her baby's breathing

D) Repeating the assessment every 5 minutes for up to 20 minutes

Answer: D

Explanation: A) Unlicensed personnel do not perform assessments.

B) The infant does not need to be swaddled.

C) The mother is not responsible for monitoring the newborn's breathing.

D) With a 5-minute Apgar of 6, this newborn is at increased risk for complications compared to those with Apgar scores in the range of 7 to 10. The nurse will reassess the client every 5 minutes for up to 20 minutes. The nurse should have resuscitative equipment ready for use.

Page Ref: 2393

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 33.D. Summarize care of newborns. Illustrate the nursing process in providing culturally competent care to the newborn.

MNL LO: Demonstrate understanding of the concept of reproduction in the provision of newborn care.

11) The nurse is providing care to a newborn born at 37 2/7 weeks' gestation. The newborn's weight is 1750 g (3 pounds, 10 ounces). Which statement would the nurse use to describe these assessment findings?
A) Preterm appropriate for gestational age
B) Full term appropriate for gestational age
C) Late preterm small for gestational age
D) Early term small for gestational age
Answer: D
Explanation: A) The infant is not preterm because it was born after 36 6/7 weeks.
B) The infant is not full term because it was born before 39 to 40 6/7 weeks.
C) The infant is not late preterm because it was born after 36 6/7 weeks.
D) The infant is early term at 37 2/7 weeks. Because the weight is below the 10th percentile, the infant's size is not appropriate for gestational age but is considered small for gestational age.
Page Ref: 2389
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.D. Summarize care of newborns. Outline alterations found in newborns.
MNL LO: Demonstrate understanding of the concept of reproduction in the provision of newborn care.

12) The nurse will commonly need to work with all *except* which member of the healthcare team to provide care to the newborn?
A) Audiology specialist
B) Cardiac surgeon
C) Lactation consultant
D) Pediatrician
Answer: B
Explanation: A) The healthcare team works together to care for the newborn. The team commonly includes an audiology specialist.
B) A cardiac surgeon will only be involved in the newborn's care if the newborn is diagnosed with a congenital cardiac disorder or birth defect.
C) The healthcare team works together to care for the newborn. The team commonly includes a lactation consultant.
D) The healthcare team works together to care for the newborn. The team commonly includes a pediatrician or neonatal specialist.
Page Ref: 2389
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the health care team. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Recognize the importance of one's own potential to contribute to effective team functioning. | Nursing Process: Implementation
Learning Outcome: 33.D. Summarize care of newborns. Summarize collaborative therapies used by interprofessional teams for newborns with alterations.
MNL LO: Demonstrate understanding of the concept of reproduction in the provision of newborn care.

Exemplar 33.E Prematurity

1) After giving birth to a preterm infant who is being cared for in the neonatal intensive care unit (NICU), a client says, "My baby doesn't seem real because she's in the hospital and I'm at home." Which action should the nurse take to promote parent-infant attachment?
A) Limit visits to the intensive care unit so as not to disrupt care the baby needs.
B) Explain that once the baby is discharged to home, she will have evidence that the baby is real.
C) Have the mother visit when the baby is asleep or resting.
D) Provide a picture of the infant including a footprint and current weight and length.
Answer: D
Explanation: A) Visits to the intensive care unit should be encouraged and supported.
B) The mother needs to begin bonding with the infant now, not wait until the baby is discharged to home.
C) The mother should try to visit with the infant when the baby is awake to encourage interaction.
D) Nurses need to take measures to promote positive parental feelings toward the preterm infant. One way to do this would be to provide the mother with a picture of the infant, including a footprint and current weight and length. This promotes bonding.
Page Ref: 2436
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation
Learning Outcome: 33.E. Summarize care of premature newborns. Describe the nursing process in assessing the premature newborn and implementing culturally competent care to the premature newborn and family.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the premature infant.

2) The mother of a preterm infant tells the nurse that she was not looking forward to having a baby and now that the baby is sick, she feels worse. Which problem is appropriate based on this data?

A) Parental role conflict

B) Impaired parenting

C) Dysfunctional family processes

D) Caregiver conflict

Answer: D

Explanation: A) Parental role conflict is seen if the role of parent is in conflict with other expectations.

B) Impaired parenting is seen if the mother is unable to fulfill the role of mother to the baby.

C) Dysfunctional family processes are seen if the addition of a baby leads to the family's inability to function as a family.

D) Caregiver conflict is the problem most appropriate for this situation at this time because the mother is expressing anger and guilt at having given birth to a premature baby.

Page Ref: 2433

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Diagnosis

Learning Outcome: 33.E. Summarize care of premature newborns. Describe the nursing process in assessing the premature newborn and implementing culturally competent care to the premature newborn and family.

MNL LO: Demonstrate understanding of the concept of reproduction in the care of the premature infant.

3) When planning the care for a preterm infant with ineffective thermoregulation, the nurse should include which intervention?

A) Keep the baby's head uncovered.

B) Rinse hands with cold water before providing care to the infant.

C) Place incubator near a window or source of fresh air.

D) Allow skin-to-skin contact with the mother to maintain warmth.

Answer: D

Explanation: A) The baby's head should be covered because the head is 25% of the baby's size and is prone to evaporative heat loss.

B) The hands should be rinsed with warm water before providing care to the infant.

C) Incubators should be moved away from drafts or open windows to reduce radiative and conductive heat loss.

D) The nurse needs to plan for a neutral thermal environment to minimize oxygen consumption, prevent cold stress, and facilitate growth of the preterm infant. To do this, the nurse should plan for the infant to have skin-to-skin contact with the mother to maintain warmth.

Page Ref: 2434

Cognitive Level: Applying

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 33.E. Summarize care of premature newborns. Describe the nursing process in assessing the premature newborn and implementing culturally competent care to the premature newborn and family.

MNL LO: Demonstrate understanding of the concept of reproduction in the care of the premature infant.

4) The nurse is instructing the parents who delivered their first child at 34 weeks' gestation. Which statements made by the parents indicate that additional teaching is needed? **Select all that apply.**
A) "Tube feedings will be required because his stomach is small."
B) "Breathing might be harder for our baby because he is early."
C) "Our baby will be in an incubator to keep him warm."
D) "The growth of our baby will be slower than if he were term."
E) "Because he came early, he will not produce urine for 2 days."
Answer: A, E
Explanation: A) Although tube feedings might be required, it would be because preterm babies lack sufficient suck and swallow reflexes to prevent aspiration.
B) Surfactant production might not be complete at 34 weeks, which leads to respiratory distress syndrome. In addition, respiratory effort is increased when the ductus arteriosus remains patent, which is common in preterm infants.
C) Preterm infants have little subcutaneous fat and have difficulty maintaining their body temperature. An incubator or radiant warmer is used to keep the baby warm.
D) Preterm infants grow more slowly than do term infants.
E) Although preterm babies have diminished kidney function due to incomplete development of the glomeruli, they will make urine.
Page Ref: 2428-2429
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 33.E. Summarize care of premature newborns. Describe the physiology and risk factors of the premature newborn.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the premature infant.

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5) The nurse is monitoring the intake and output for a preterm infant. Which action by the nurse indicates correct assessment technique when monitoring urine output?
A) Document "unable to obtain" on the graphic sheet.
B) Apply an external condom catheter.
C) Insert an indwelling urinary catheter.
D) Weigh diapers.
Answer: D
Explanation: A) Documenting "unable to obtain" on the graphic sheet does not support the need to accurately measure the infant's output.
B) The nurse should not apply an external condom catheter on the infant.
C) The nurse should not insert an indwelling urinary catheter.
D) Weight change is one of the most sensitive indicators of fluid balance. Weighing diapers is the intervention used to accurately measure the output of an infant.
Page Ref: 2435
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 33.E. Summarize care of premature newborns. Describe the nursing process in assessing the premature newborn and implementing culturally competent care to the premature newborn and family.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the premature infant.

6) The nurse is preparing to provide an enteral feeding to a preterm infant. Which is the priority nursing action prior to administering the feeding?

A) Weigh the current diaper.
B) Measure abdominal girth.
C) Weigh the baby.
D) Measure pulse oximetry.

Answer: B

Explanation: A) Weighing diapers assesses fluid volume status.
B) Before each feeding, the nurse should measure the abdominal girth to determine abdominal distention, which is seen in necrotizing enterocolitis or paralytic ileus.
C) Weighing the baby assesses for fluid volume status.
D) Measuring pulse oximetry is an intervention for assessing oxygenation.

Page Ref: 2435

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 33.E. Summarize care of premature newborns. Describe the nursing process in assessing the premature newborn and implementing culturally competent care to the premature newborn and family.

MNL LO: Demonstrate understanding of the concept of reproduction in the care of the premature infant.

7) The nurse is caring for a premature infant with a central line. The otherwise healthy, growing infant suddenly develops apnea, bradycardia, and metabolic acidosis. Which condition most likely caused this change in health status?
A) Hyperbilirubinemia
B) Bacterial sepsis
C) Hypoglycemia
D) Intracranial hemorrhage
Answer: B
Explanation: A) These symptoms are not associated with hyperbilirubinemia.
B) The sudden onset of apnea, bradycardia, and metabolic acidosis in a premature infant with a central line in place who had previously been growing and doing well is suggestive of bacterial sepsis.
C) These symptoms are not associated with hypoglycemia.
D) These symptoms are not associated with intracranial hemorrhage.
Page Ref: 2429
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.E. Summarize care of premature newborns. Describe the physiology and risk factors of the premature newborn.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the premature infant.

8) The nurse is assessing a premature newborn who is being cared for in the newborn intensive care unit (NICU). Which assessment finding indicates the newborn is experiencing respiratory distress?
A) Acrocyanosis
B) Respiratory rate of 58 breaths per minute
C) Substernal and intercostal retractions
D) Abdominal breathing
Answer: C
Explanation: A) Acrocyanosis is considered a normal assessment finding in the premature newborn.
B) A respiratory rate of 58 breaths per minute is considered a normal assessment finding in the premature newborn.
C) A premature newborn who is experiencing retraction may be in respiratory distress.
D) Abdominal breathing is considered a normal assessment finding in the premature newborn.
Page Ref: 2434
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 33.E. Summarize care of premature newborns. Describe the nursing process in assessing the premature newborn and implementing culturally competent care to the premature newborn and family.

MNL LO: Demonstrate understanding of the concept of reproduction in the care of the premature infant.

9) Which factor contributes to increased respiratory complications in the preterm infant?
A) Increased constriction of blood vessels
B) Decreased prostaglandin E levels
C) Absence of muscular coat on pulmonary blood vessels
D) Inadequate surfactant
Answer: D
Explanation: A) In preterm infants, the muscular coat on pulmonary blood vessels is incompletely developed, not absent, leading to decreased constriction of blood vessels.
B) Prostaglandin E levels are increased, not decreased.
C) In preterm infants, the muscular coat on pulmonary blood vessels is incompletely developed, not absent.
D) The preterm neonate is unable to produce adequate amounts of surfactant in the lungs, decreasing compliance and increasing the pressure needed to expand the lungs with air.
Page Ref: 2427
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.E. Summarize care of premature newborns. Describe the physiology and risk factors of the premature newborn.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the premature infant.

10) Because of the immature development of the kidney, the nurse needs to assess preterm infants for which condition?
A) Metabolic acidosis
B) Metabolic alkalosis
C) Respiratory acidosis
D) Respiratory alkalosis
Answer: A
Explanation: A) The buffering capacity of the kidney is reduced in a preterm infant, predisposing the neonate to metabolic acidosis. Bicarbonate is excreted at a lower serum level, and acid is excreted more slowly. Therefore, the neonate is at higher risk for metabolic acidosis.
B) The neonate is not at higher risk for metabolic alkalosis.
C) Respiratory acidosis would be due to changes in lung physiology, not kidney physiology.
D) Respiratory alkalosis would be due to changes in lung physiology, not kidney physiology.
Page Ref: 2428
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.E. Summarize care of premature newborns. Describe the physiology and risk factors of the premature newborn.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the premature infant.

11) A premature newborn's neuronal immaturity may contribute to which complication?
A) Apnea of prematurity
B) Patent ductus arteriosus
C) Respiratory distress syndrome
D) Anemia of prematurity
Answer: A
Explanation: A) Apnea of prematurity is primarily a result of neuronal immaturity, causing irregular breathing patterns and cessation of breathing for 20 seconds or longer in preterm infants.
B) PDA has another etiology related to the premature development of the neonate.
C) Respiratory distress syndrome has another etiology related to the premature development of the neonate.
D) Anemia of prematurity has another etiology related to the premature development of the neonate.
Page Ref: 2432
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 33.E. Summarize care of premature newborns. Summarize alterations found in premature newborns.
MNL LO: Demonstrate understanding of the concept of reproduction in the care of the premature infant.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 34 Assessment

The Concept of Assessment

1) The nurse in the clinic is assessing an adult client who has signs and symptoms of heart failure. Which lifestyle factor would be most useful for the nurse to assess before developing the client teaching plan?
A) The client's occupation
B) The client's diet
C) The client's usual sleep schedule
D) The client's marital status
Answer: B
Explanation: A) Gathering psychosocial information such as the client's occupation is important, but in this case, it is not directly related to the client's current problem and teaching needs.
B) For clients who have heart failure, the nurse should ask questions aimed at obtaining information about lifestyle factors that may be contributing to the heart failure, such as diet.
C) Although sleep schedule is a lifestyle factor about which the nurse should inquire, it is less likely than diet to be a contributing factor to heart failure.
D) Gathering psychosocial information such as the client's marital status is important, but in this case, it is not directly related to the client's current problem and teaching needs.
Page Ref: 2451
Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment
Learning Outcome: 34.2. Analyze the principal methods used to collect data during a nursing assessment.
MNL LO: Analyze the concept of assessment and its application to nursing care.

2) The nurse is preparing to assess a client who is experiencing difficulty breathing. Before palpating the client's abdomen, which nursing action is appropriate?
A) Administering 10 L of oxygen to the client
B) Having the client seated
C) Placing the client in a modified Sims position
D) Asking the client to bend over a table
Answer: B
Explanation: A) Depending on the client's underlying condition, administering 10 L of oxygen may be excessive.
B) Abdomen palpation is usually done in the supine position, but a client with difficulty breathing would not tolerate that position well. Instead, the nurse should position the client seated to perform the assessment.
C) Having the client lie in a modified Sims position could compromise the client's ability to breathe effectively.
D) A client who is experiencing dyspnea would not be asked to bend over a table.
Page Ref: 2458
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Evidence and best practices for nursing. | Nursing Process: Implementation
Learning Outcome: 34.2. Analyze the principal methods used to collect data during a nursing assessment.

MNL LO: Analyze the concept of assessment and its application to nursing care.

3) The nurse is preparing to conduct a physical examination of a client's head and neck area. The client is paralyzed from the neck down. Which action by the nurse is appropriate when conducting the physical assessment of this area?
A) Supporting the client during the examination
B) Placing the client in an armless regular chair
C) Placing the client in Sims position
D) Placing the client in supine position
Answer: A
Explanation: A) The client who is paralyzed from the neck down is not able to support their body. When considering positioning, the nurse should recognize that the client will require support during the procedure.
B) This client would not be able to sit in an armless chair, which has no support.
C) Sims position would not allow the nurse to observe the client adequately.
D) Placing the client supine will not allow the nurse full view of the client during observation.
Page Ref: 2458
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Implementation
Learning Outcome: 34.2. Analyze the principal methods used to collect data during a nursing assessment.
MNL LO: Analyze the concept of assessment and its application to nursing care.

4) A client is complaining of pain in the lower-left quadrant of his abdomen. The nurse prepares to auscultate the lower abdomen and notes that the client has a great deal of hair there. Which action by the nurse is appropriate prior to auscultating the client's abdomen?
A) Moistening the abdominal hair
B) Documenting that the client has hirsutism
C) Cutting the client's hair over the entire abdomen
D) Discontinuing the use of auscultation and palpating the abdomen only
Answer: A
Explanation: A) If the client has excess body hair, the nurse should dampen the hair so that it lies flat against the abdomen to enhance sound transmission.
B) Hirsutism includes excess hair all over the entire body, not just the abdomen.
C) The nurse would not shave the client's hair for auscultation.
D) The client complains of abdominal pain, so auscultation would be a necessary part of a thorough examination because the nurse would need to listen to bowel sounds.
Page Ref: 2460
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment
Learning Outcome: 34.2. Analyze the principal methods used to collect data during a nursing assessment.
MNL LO: Analyze the concept of assessment and its application to nursing care.

5) A client presents with a temperature of 102°F, complains of nausea, and has experienced vomiting and diarrhea for 12 hours. The nurse notes that the client's mucous membranes are pale and dry and suspects that the client is dehydrated. Which action by the nurse is the most appropriate?
A) Ask the client's family for more information.
B) Assess for pedal edema.
C) Assess skin turgor.
D) Repeat the temperature measurement.
Answer: C
Explanation: A) Asking the family for more information will not provide adequate support for the treatment of dehydration.
B) Pedal edema would indicate fluid volume overload and not dehydration.
C) A client who presents with hyperthermia, vomiting, diarrhea, and pale, dry mucous membranes is likely dehydrated and requires assessment to confirm this suspicion. An appropriate action by the nurse is to assess the client's skin turgor, which can provide more support for a diagnosis of dehydration.
D) Only measurements that are extremely abnormal need to be repeated in stable clients.
Page Ref: 2462
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment
Learning Outcome: 34.5. Analyze the cues used when interpreting data from a nursing assessment.
MNL LO: Analyze the concept of assessment and its application to nursing care.

6) The nurse is preparing to examine a toddler's ear canals with an otoscope. Which actions by the nurse are appropriate? **Select all that apply.**
A) Having the child sit on the examination table
B) Having the child play with the equipment
C) Having the child sit on the parent's lap
D) Telling the child the examination will not hurt
E) Asking the child to tilt the head
Answer: B, C
Explanation: A) The best way to get a child of this age to cooperate is to have the child sit on the parent's lap.
B) The best way to get a child of this age to cooperate is to let the child play with the equipment and perhaps use the equipment on a doll.
C) The best way to get a child of this age to cooperate is to let the child sit on the parent's lap.
D) Most children of this age need to see for themselves that a procedure will not hurt; simply telling the child that the procedure won't be painful is not effective.
E) Asking the child to tilt the head does not encourage cooperation.
Page Ref: 2467
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Evidence and best practices for nursing. | Nursing Process: Assessment
Learning Outcome: 34.7. Differentiate considerations related to the assessment of patients throughout the lifespan.
MNL LO: Analyze the concept of assessment and its application to nursing care.

7) The nurse is assessing an older adult client during a routine health maintenance visit. To assess the client's range of motion of the knees, which action by the nurse is appropriate?
A) Seat the client and extend each knee until the client alerts the nurse of severe pain.
B) Seat the client and extend each knee until the client alerts the nurse of any pain whatsoever.
C) Place the client prone and gently lift the entire right leg, followed by the entire left leg.
D) Have the client stand and extend each knee as far as it will go.
Answer: B
Explanation: A) The knee should not be forced beyond the pain limit.
B) To assess the range of motion of the knees, the client should be placed in a sitting position. The client should be instructed to alert the nurse at the first sign of discomfort when checking range of motion of the knees.
C) Placing the client prone and lifting the entire leg checks the range of motion of the hips.
D) The client should not be asked to stand when assessing range of motion of the knees.
Page Ref: 2456, 2471
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment
Learning Outcome: 34.7. Differentiate considerations related to the assessment of patients throughout the lifespan.
MNL LO: Analyze the concept of assessment and its application to nursing care.

8) The nurse is conducting a physical assessment of a middle-aged female client during an annual exam. Which areas should the nurse assess that are particularly relevant to this age group? **Select all that apply.**
A) Speech and language
B) Body development and growth
C) Sleeping patterns
D) Ability to carry out activities of daily living (ADLs)
E) Body mass index (BMI) measurement
Answer: D, E
Explanation: A) Speech and language are more appropriate to assess in pediatric clients.
B) Body development and growth are more appropriate to assess in pediatric clients.
C) Sleeping patterns are more appropriate to assess in pediatric clients.
D) Areas of assessment that are relevant to middle-aged adults include the ability to carry out ADLs.
E) Areas of assessment that are relevant to middle-aged adults include BMI measurement to assess for disease risk.
Page Ref: 2470
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment
Learning Outcome: 34.7. Differentiate considerations related to the assessment of patients throughout the lifespan.
MNL LO: Analyze the concept of assessment and its application to nursing care.

9) The nurse is caring for a new older adult client who speaks a foreign language and who does not speak English. Which action by the nurse is appropriate when conducting the health history portion of the assessment?
A) Speaking in a loud tone when addressing the client
B) Providing the client with educational materials that are written in English
C) Asking the client's adult son to translate during the assessment
D) Having a medical translator available during the health history
Answer: D
Explanation: A) Although the nurse may need to increase the volume of speech because of age-related changes in the client's hearing, this is not an appropriate action until the nurse determines that the client is hard of hearing.
B) Educational material should be provided to the client in the client's native language.
C) Asking a family member to translate during an assessment can violate the client's privacy.
D) Because the client speaks a foreign language, the nurse will need a medical translator to be available during the health history portion of the assessment.
Page Ref: 2452
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment
Learning Outcome: 34.2. Analyze the principal methods used to collect data during a nursing assessment.

MNL LO: Analyze the concept of assessment and its application to nursing care.

10) The nurse is conducting a health history as part of a nursing assessment. The client says to the nurse, "I am allergic to penicillin." Which assessment question would best help the nurse learn more about the client's allergy?
A) "Where did you experience the reaction?"
B) "What type of reaction occurred?"
C) "How long did your symptoms last?"
D) "Do any other family members have this same allergy?"
Answer: B
Explanation: A) The location of the reaction is important, but the priority is determining the type of reaction the client experienced.
B) The nurse should ask the client to provide more information about the type of reaction that occurred when the penicillin was administered.
C) How long the symptoms lasted is important, but the priority is determining the type of reaction the client experienced.
D) Asking whether any other family members have the same allergy will not provide the nurse with useful information.
Page Ref: 2451
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment
Learning Outcome: 34.2. Analyze the principal methods used to collect data during a nursing assessment.
MNL LO: Analyze the concept of assessment and its application to nursing care.

11) The nurse is conducting a physical assessment of a middle-aged client upon admission to the cardiovascular care unit for cardiopulmonary problems. Which position is likely to be contraindicated for this client?
A) Sitting with back unsupported
B) Supine (horizontal recumbent)
C) Dorsal recumbent (back-lying)
D) Sims (side-lying)
Answer: C
Explanation: A) Sitting (with back supported or unsupported) is better tolerated by clients with cardiopulmonary illness.
B) Supine (horizontal recumbent) is better tolerated by clients with cardiopulmonary illness.
C) The dorsal recumbent position (back-lying with knees flexed and hips externally rotated) is usually contraindicated for clients with cardiopulmonary problems because of the increased physiologic stress that this position places on the body.
D) Side-lying (Sims) position is better tolerated by clients with cardiopulmonary illness.
Page Ref: 2458
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment
Learning Outcome: 34.2. Analyze the principal methods used to collect data during a nursing assessment.

MNL LO: Analyze the concept of assessment and its application to nursing care.

12) The nurse is assessing an older adult client who is confused. The client is accompanied by an adult son. Which person should the nurse use as a primary source of data when assessing this client?
A) The client himself
B) The client's adult son
C) A nurse who cares for the client at the retirement home
D) The client's primary healthcare provider
Answer: A
Explanation: A) The client is the only person who is considered a primary source of data.
B) Family members are considered secondary sources of data.
C) Health professionals are considered secondary sources of data.
D) Health professionals are considered secondary sources of data.
Page Ref: 2448
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment
Learning Outcome: 34.1. Analyze the types and sources of data collected during a nursing assessment.
MNL LO: Analyze the concept of assessment and its application to nursing care.

13) The nurse educator is providing information to a group of new nurses regarding appropriate assessment techniques that can be applied across the lifespan. Which statements should the educator include in the teaching session? **Select all that apply.**
A) "Auscultate the chest while the client is sleeping to obtain the most accurate assessment of the heart."
B) "Use standard precautions during the history and physical examination process."
C) "Perform invasive procedures like pharyngeal and otic exams at the end of the assessment."
D) "Use age-appropriate terminology for explaining procedures and actions."
E) "Use the assessment process to teach about exam procedures and findings."
Answer: B, D, E
Explanation: A) Conducting a cardiovascular assessment during sleep is appropriate for some pediatric clients, but it would be considered an intrusion or violation of privacy by older pediatric and adult clients.
B) Following standard precautions is an action that the nurse can implement across the lifespan when assessing clients.
C) Performing invasive procedures at the end of the assessment is appropriate for pediatric clients but not necessary for adult clients.
D) Employing age-appropriate terminology is an action that the nurse can implement across the lifespan when assessing clients.
E) Using the examination to provide teaching is an action that the nurse can implement across the lifespan when assessing clients.
Page Ref: 2464-2466
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Implementation
Learning Outcome: 34.7. Differentiate considerations related to the assessment of patients throughout the lifespan.
MNL LO: Analyze the concept of assessment and its application to nursing care.

14) The nurse is reviewing the medical record for a school-age client prior to a scheduled health maintenance visit. Which data from the record indicates that the client is overweight?
A) Body mass index (BMI) >85th percentile
B) BMI >95th percentile
C) 25% increase in weight in a 6-month period
D) 35% increase in weight in a 6-month period
Answer: A
Explanation: A) A child with a BMI greater than the 85th percentile is considered overweight.
B) A child with a BMI greater than the 95th percentile is considered obese.
C) Percentage of weight gain in a 6-month period (regardless of baseline) does not determine whether a client is overweight or obese.
D) Percentage of weight gain in a 6-month period (regardless of baseline) does not determine whether a client is overweight or obese.
Page Ref: 2466
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment
Learning Outcome: 34.7. Differentiate considerations related to the assessment of patients throughout the lifespan.
MNL LO: Analyze the concept of assessment and its application to nursing care.

15) The nurse is assessing an older adult client who experienced a myocardial infarction (MI) a few months ago. The client states, "I don't feel like doing much. I feel okay physically, but I just don't want to be around anyone." Based on this data, which tool should the nurse use to further assess the client?
A) Get-Up-and-Go Test
B) Barthel Index of Activities of Daily Living
C) Geriatric Depression Scale
D) Short Portable Mental Status tool
Answer: C
Explanation: A) The Get Up and Go Test is used to assess gait and balance.
B) The Barthel Index of Activities of Daily Living evaluates a disability for if, and to what extent, support is needed.
C) The most appropriate tool for the nurse to use in further assessing the client is the Geriatric Depression Scale. This instrument is designed to assess low mood and diminished self-esteem, as well as loss of interest in activities that the client normally enjoys.
D) The Short Portable Mental Status tool focuses on the mental processes of knowing and understanding.
Page Ref: 2472
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment

Learning Outcome: 34.7. Differentiate considerations related to the assessment of patients throughout the lifespan.
MNL LO: Analyze the concept of assessment and its application to nursing care.

16) Which type of data are detectable by an observer or can be measured or tested against an accepted standard?
A) Subjective data or symptoms
B) Objective data or symptoms
C) Subjective data or signs
D) Objective data or signs
Answer: D
Explanation: A) Subjective data, also referred to as symptoms, are feelings or perceptions that can be described or verified only by the client. Itching, pain, and feelings of anxiety are examples of subjective data.
B) Objective data, also referred to as signs, are detectable by an observer or can be measured or tested against an accepted standard. Examples of objective data include discoloration of the skin and blood pressure readings.
C) Subjective data, also referred to as symptoms, are feelings or perceptions that can be described or verified only by the client. Itching, pain, and feelings of anxiety are examples of subjective data.
D) Objective data, also referred to as signs, are detectable by an observer or can be measured or tested against an accepted standard. Examples of objective data include discoloration of the skin and blood pressure readings.
Page Ref: 2448
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment
Learning Outcome: 34.1. Analyze the types and sources of data collected during a nursing assessment.
MNL LO: Analyze the concept of assessment and its application to nursing care.

17) Which sounds would the nurse least likely assess during percussion of a healthy client?
A) Tympany
B) Hyperresonance
C) Dullness
D) Flatness
Answer: B
Explanation: A) Tympany is a musical or drumlike sound produced from an air-filled stomach.
B) Hyperresonance is not produced in the healthy body. It is described as booming that can be heard over an emphysematous lung.
C) Dullness is a thudlike sound produced by dense tissue such as the liver, spleen, or heart.
D) Flatness is an extremely dull sound produced by very dense tissue, such as muscle or bone.
Page Ref: 2460
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment
Learning Outcome: 34.2. Analyze the principal methods used to collect data during a nursing assessment.
MNL LO: Analyze the concept of assessment and its application to nursing care.

18) For which client would the nurse omit using the Denver II tool during a well-child assessment?

A) A male client
B) A client aged 7 or older
C) A female client
D) A client aged 6 or younger
Answer: B
Explanation: A) This tool is used with both male and female clients.
B) The Denver II tool would not be used for clients aged 7 or older.
C) This tool is used with both male and female clients.
D) The Denver II tool is a screening test administered to well children between birth and 6 years of age. It is designed to test 20 simple tasks and items in four sectors: personal-social, fine motor adaptive, language, and gross motor.
Page Ref: 2449
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment
Learning Outcome: 34.7. Differentiate considerations related to the assessment of patients throughout the lifespan.
MNL LO: Analyze the concept of assessment and its application to nursing care.

19) For which reason would the nurse assess a client with the Braden Scale?
A) To determine risk for falls
B) To determine risk for pressure ulcers
C) To determine risk for malnutrition
D) To determine ability to complete activities of daily living.
Answer: B
Explanation: A) Fall risk would be assessed with a tool such as the Get-Up-and-Go Test, Berg Balance Test, Single Leg Stance Test, or Fullmer SPICES instrument.
B) The Braden Scale is used to determine an individual's risk for developing pressure ulcers.
C) Risk for malnutrition would be assessed with a tool such as the Mini-Nutritional Assessment.
D) Ability to complete activities of daily living (ADLs) would be assessed with a device such as Katz's ADL Scale or the Instrumental ADL tool.
Page Ref: 2472
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Transcultural approaches to health. | Nursing Process: Assessment
Learning Outcome: 34.2. Analyze the principal methods used to collect data during a nursing assessment.
MNL LO: Analyze the concept of assessment and its application to nursing care.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e **(Pearson)**
Module 35 Caring Interventions

The Concept of Caring Interventions

1) The family members of a recently deceased client wrote a letter to the unit manager, expressing their appreciation for the way the client was treated while dying in the hospital. The family mentioned characteristics that indicate the nurses were caring. Which behaviors did the family most likely use to explain the caring actions of the nurses? **Select all that apply.**
A) Recognizing a change in the client's status
B) Responding to the client's needs
C) Attending to the client and family
D) Maintaining a positive attitude
E) Established limits with the client
Answer: A, B, C, D
Explanation: A) A characteristic of caring is recognizing a change in the client's status.
B) A characteristic of caring is responding to the client's needs.
C) A characteristic of caring is attending to the client and family.
D) A characteristic of caring is maintaining a positive attitude.
E) Establishing or setting limits is an action that a nurse would perform as part of self-care actions.
Page Ref: 2477
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Context and Environment: Examine personal beliefs, values, and biases with regard to respect for persons, human dignity, equality, and justice; Explore ideas of nurse caring and compassion. | Nursing Process: Evaluation
Learning Outcome: 35.1. Outline nursing theories that bridge the gap between theory and practice.
MNL LO: Analyze the concept of caring interventions and its application to nursing care.

2) The nurse is caring for an older client. In which way should the nurse demonstrate comportment with the client?
A) Respect the client
B) Speak confidently
C) Participate in the client's experience
D) Demonstrate knowledge in capabilities
Answer: A
Explanation: A) Comportment is one of the six Cs of caring in nursing and is demonstrated by having an appropriate demeanor, dress, and language that is in harmony with a caring presence. The nurse would also present as someone who respects others and in turn demands respect.
B) Confidence is one of the six Cs of caring in nursing and is demonstrated by speaking confidently.
C) Compassion is one of the six Cs of caring in nursing and is demonstrated by participating in the experience of another.
D) Competence is one of the six Cs of caring in nursing and is demonstrated by having the knowledge to perform professional responsibilities.
Page Ref: 2478
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 35.2. Outline the relationship between caring interventions and other concepts.
MNL LO: Analyze the concept of caring interventions and its application to nursing care.

3) A client with a history of smoking reports "thinking about" attending smoking cessation group sessions. Which stage of change should the nurse document the client is demonstrating?
A) Action
B) Preparation
C) Contemplative
D) Pre-contemplative
Answer: C
Explanation: A) The action stage begins when the client starts making changes in one or more behaviors.
B) The client who decides to make changes moves to the third stage, preparation, which is when the client begins to make plans for behavior change.
C) The patient becomes aware of the problem and begins to consider making a change, in the contemplation stage.
D) During the precontemplation stage, clients are unaware a problem needs to be addressed, or they are unable to accept that there is a problem.
Page Ref: 2481
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 35.3. Discuss application of stage theory as a caring intervention to influence behavior change.

MNL LO: Analyze the concept of caring interventions and its application to nursing care.

4) During a performance appraisal, a unit manager praises a staff nurse on the ability to use presencing when caring for terminally ill clients. Which behaviors did the nurse demonstrate that would exemplify this caring behavior? **Select all that apply.**
A) Discussions with clients
B) Instructing clients on how they should perform certain functions
C) Sitting quietly with clients
D) Validating the client's experience through active listening
E) Guaranteeing quality and safety in care
Answer: A, C
Explanation: A) Presencing is a nursing concept that involves the interpersonal arts of perception and communication. Discussions with clients is an action of presencing.
B) Instructing clients on how they should perform certain functions empowers the client.
C) Presencing is a nursing concept that involves the interpersonal arts of perception and communication. Silent immersion is an action of presencing.
D) Validating the client's experience through active listening demonstrates compassion.
E) Guaranteeing quality and safety in care demonstrates competence.
Page Ref: 2482
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Context and Environment: Examine personal beliefs, values, and biases with regard to respect for persons, human dignity, equality, and justice; Explore ideas of nurse caring and compassion. | Nursing Process: Evaluation
Learning Outcome: 35.4. Analyze holistic nursing as it relates to caring interventions.
MNL LO: Analyze the concept of caring interventions and its application to nursing care.

5) The nurse decides to take a few days of personal time to invest in self-nurturing activities. Which activities indicate the nurse is taking steps to care for self? **Select all that apply.**
A) Sleeping 4 hours each night
B) Eating one meal a day
C) Being active in church
D) Participating in regular exercise
E) Participating in daily meditation
Answer: C, D, E
Explanation: A) Sleeping for 4 hours each night does not help the nurse care for self.
B) Eating only once a day does not help the nurse care for self.
C) Some examples of activities that can help the nurse care for self include prayer.
D) Some examples of activities that can help the nurse care for self include regular exercise.
E) Some examples of activities that can help the nurse care for self include meditation.
Page Ref: 2486
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.C.5. Value the need for continuous improvement in clinical practice based on new knowledge. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; Be open and non-judgmental. | Nursing Process: Implementation
Learning Outcome: 35.6. Analyze the importance of nurses caring for themselves.
MNL LO: Analyze the concept of caring interventions and its application to nursing care.

6) A hospital is preparing for the American Nurses' Credentialing Center's magnet hospital designation process. Nurse representatives on the Magnet Council consider several Professional Practice Models (PPMs) as their approach to nursing care. After selecting a PPM model, members of the Council plan a series of nursing grand rounds. These focus on the six Cs of caring in nursing: compassion, competence, confidence, conscience, commitment, and comportment. Which nursing theory, philosophical approach, or framework of caring have the nurses decided to adopt?
A) Watson's Theory of Human Care
B) Leininger's Theory of Culture Care Diversity and Universality
C) Roach's Theory of Caring as the Human Mode of Being
D) Boykin and Schoenhofer's Nursing as Caring Theory
Answer: C
Explanation: A) Watson's Theory of Human Care emphasizes the role of authentic caring relationships in healing.
B) Leininger's Theory of Culture Care Diversity emphasizes actions that preserve, maintain, and accommodate the cultures of diverse clients.
C) Roach's Theory of Caring as the Human Mode of Being includes the six Cs of caring in nursing.
D) Boykin and Schoenhofer's Nursing as Caring Theory describes caring as an essential aspect of nursing and a process rather than a mere goal.
Page Ref: 2478
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Examine personal beliefs, values, and biases with regard to respect for persons, human dignity, equality, and justice; Explore ideas of nurse caring and compassion. | Nursing Process: Implementation
Learning Outcome: 35.1. Outline nursing theories that bridge the gap between theory and practice.
MNL LO: Analyze the concept of caring interventions and its application to nursing care.

7) The nurse in a rural community is employed in a facility that has had a shortage of nurses for several years. As a result, several nurses have left the institution citing burnout. To avoid risking burnout, the nurse regularly works out, practices yoga, socializes with friends once or twice a week, and participates in at least one annual national or state nursing conference. This approach to work-life balance reflects which concept within the framework of Caring Interventions?

A) Self-compassion
B) Self-care
C) Self-control
D) Self-actualizing

Answer: B

Explanation: A) Self-care encompasses self-compassion.

B) Given the circumstances in which the nurse finds himself, the nurse has initiated the Caring Intervention of self-care to better cope with a stressful work environment.

C) Exercising self-control is an aspect of self-care.

D) Self-actualizing is an aspect of self-care.

Page Ref: 2486

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: III.C.5. Value the need for continuous improvement in clinical practice based on new knowledge. | AACN Domains and Competencies: 10.1 Demonstrate a commitment to personal health and well-being. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; Be open and non-judgmental. | Nursing Process: Implementation

Learning Outcome: 35.6. Analyze the importance of nurses caring for themselves.

MNL LO: Analyze the concept of caring interventions and its application to nursing care.

8) When a client's or family's wishes about a client's care clash with what the nurse believes would be the best possible care for the client, this could cause a conflict between caring interventions and which nursing concept?
A) Accountability
B) Ethics
C) Quality Improvement
D) Communication
Answer: B
Explanation: A) The conflict between the client's wishes and the nursing care does not demonstrate the concept of accountability.
B) Conflict between providing the best possible care for the client and the family's or client's wishes could lead to the nurse experiencing moral distress, which could lead to burnout. This is an ethical conflict for the nurse.
C) The nurse may use this situation to analyze institutional policies for quality improvement, but this process would not involve conflict.
D) Even in the midst of this conflict, the nurse should maintain the highest standards of communication.
Page Ref: 2480
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Codes of ethics, regulatory and professional standards, ethical decision-making models; Scope of practice considerations; Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Assessment

Learning Outcome: 35.2. Outline the relationship between caring interventions and other concepts.
MNL LO: Analyze the concept of caring interventions and its application to nursing care.

9) In holistic nursing, the nurse emphasizes the client's personal responsibility in maintaining health. This idea is most closely related to which concept in caring interventions?

A) Nursing presence

B) Empowerment

C) Compassion

D) Competence

Answer: B

Explanation: A) Nursing presence is less likely to help clients take personal responsibility for their own health.

B) Empowerment is the process whereby the client develops the autonomy to identify their own health needs in lieu of being instructed how to do so. This helps the client take personal responsibility in maintaining health.

C) Compassion is less likely to help clients take personal responsibility for their own health.

D) Competence is less likely to help clients take personal responsibility for their own health.

Page Ref: 2482

Cognitive Level: Understanding

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: I.B.10. Engage patient or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Respect the patient's dignity, uniqueness, integrity, and self-determination, and his or her own power and self-healing processes. | Nursing Process: Implementation

Learning Outcome: 35.4. Analyze holistic nursing as it relates to caring interventions.

MNL LO: Analyze the concept of caring interventions and its application to nursing care.

10) The pediatric nurse is caring for a 17-year-old client who has type 1 diabetes. Which caring intervention can the nurse implement as the client transitions to adulthood?
A) Advocate for the client to receive pain-relieving interventions for routine procedures such as blood glucose tests.
B) Encourage the client to use a retail clinic for acute care problems unrelated to diabetes.
C) Emphasize the importance of having a medical home to routinely monitor and treat chronic conditions.
D) Provide recommendations for a provider who can integrate all findings from specialists into a comprehensive overview.
Answer: C
Explanation: A) The use of pain-relieving interventions for routine procedures is more appropriate for infants, not adolescents or young adults.
B) Because of the need for consistent care and follow-up, a retail clinic would not be beneficial for this client.
C) A large care gap exists as young adults transition from pediatric care, monitored by parents, into autonomous primary care. Many young adults neglect to get care for chronic childhood conditions such as asthma or diabetes, so nurses should emphasize the importance of having a medical home and routinely monitoring and treating chronic conditions.
D) Finding a provider who can integrate all findings from specialists is more important for older adults than for young adults.
Page Ref: 2485
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.5. Describe strategies to empower patients or families in all aspects of the health care process. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Communicate effectively with different individuals (team members, other care providers, patients, families, etc.) so as to minimize risks associated with handoff among providers and across transitions in care. | Nursing Process: Implementation

Learning Outcome: 35.5. Differentiate caring interventions appropriate for patients at different stages throughout the lifespan.
MNL LO: Analyze the concept of caring interventions and its application to nursing care.

11) The nurse is caring for an older adult client who visits the clinic semiannually to help maintain quality of life. When providing caring interactions to this client, which intervention should the nurse avoid?
A) Self-care
B) Assessment for mental health problems
C) Referral to a geriatrician
D) Use of elderspeak
Answer: D
Explanation: A) Self-care is related to the nurse caring for one's self, not the nurse caring for a client.
B) Assessments of older adults should include mental health problems.
C) Older adults may be referred to a geriatrician as needed.
D) Elderspeak is a simplified speech characterized by shorter sentences and words. This type of speech shows a negative attitude toward older adults, especially adults who are generally healthy and are only seeking care to enhance quality of life.
Page Ref: 248
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.C.5. Recognize personally held attitudes about working with patients from different ethnic, cultural and social backgrounds. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Demonstrate respect for all persons and for human dignity, equality, and justice. | Nursing Process: Implementation
Learning Outcome: 35.5. Differentiate caring interventions appropriate for patients at different stages throughout the lifespan.
MNL LO: Analyze the concept of caring interventions and its application to nursing care.

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Module 36 Clinical Decision Making

The Concept of Clinical Decision Making

1) The nurse receives a shift report and is preparing to care for clients assigned on a medical-surgical unit. Which client should the nurse plan to assess first?
A) The client who needs assistance with bath
B) The client who needs help ambulating to the bathroom
C) The client with a pain rating of 3/10
D) The client experiencing shortness of breath
Answer: D
Explanation: A) The nurse can delegate assisting a client who needs help with a bath.
B) The nurse can delegate the ambulation of a client.
C) The risk for the client with mild pain is not as severe as that for the client with dyspnea.
D) The nurse begins by assessing the client who is at the greatest risk, who in this case is the client having trouble breathing.
Page Ref: 2507
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.C.14. Appreciate shared decision making with empowered patients and families, even when conflicts occur. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Assessment
Learning Outcome: 36.2. Analyze the components of clinical decision making.
MNL LO: Analyze the concept of clinical decision making and its application to nursing care.

2) A client with congestive heart failure (CHF) is having difficulty breathing. Before leaving the room, the nurse ensures the client has an overbed table to lean on when awake if needed to ease breathing. Which technique did the nurse use to make this decision?
A) Delegating a task
B) Priority setting
C) Conflict resolution
D) Critical thinking
Answer: D
Explanation: A) Delegating involves giving the task to another team member.
B) Priority setting involves deciding which task to perform first.
C) There is no conflict in this decision. Conflict resolution usually involves a compromise that affects two sides that are in disagreement.
D) After assessing the client, the nurse sets goals for and with the client. To arrive at the goal, the nurse uses critical thinking to make the decision to provide the client with optimum ability to breathe.
Page Ref: 2493
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Planning
Learning Outcome: 36.1. Analyze the use of critical thinking skills in nursing.
MNL LO: Analyze the concept of clinical decision making and its application to nursing care.

3) A postoperative client prescribed pain medication every 4 to 6 hours is requesting medication every 6 hours. At 4 hours the client's pain level is 8 on a rating scale of 1 to 10. The nurse decides to give the pain medication now. In which way should the nurse's action be exemplified?
A) Meeting a client goal
B) Time management skills
C) Prioritizing the client's care
D) Responding to a change in the client's condition
Answer: D
Explanation: A) The goal has not been met if the client is experiencing pain.
B) Time management is completing the assigned tasks in the given time frame by organizing and using efficiency.
C) Prioritizing involves choosing tasks in order of importance.
D) Each client has a plan of care, but it is the nurse who constantly evaluates the client for changes that the nurse responds to, if needed.
Page Ref: 2502
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Evaluation
Learning Outcome: 36.1. Analyze the use of critical thinking skills in nursing.
MNL LO: Analyze the concept of clinical decision making and its application to nursing care.

4) The nurse is assigned two clients. One client needs postoperative teaching in preparation for discharge, and the other client with pneumonia has a $PaCO_2$ of 85. For which reason does the nurse decide to see the client with pneumonia first?
A) The nurse can delegate postoperative teaching to unlicensed assistive personnel (UAP).
B) The client with pneumonia needs more care than the client needing postoperative teaching.
C) The client with pneumonia may be experiencing respiratory distress.
D) The room of the client with pneumonia is closer than that of the client needing postoperative teaching.
Answer: C
Explanation: A) The nurse cannot delegate discharge teaching to a UAP; even if delegation were permitted, the nurse would see the client with a high $PaCO_2$ as being the greater priority.
B) The client with pneumonia probably needs more care than the client preparing for discharge, but the reason for the decision is based on a potentially critical need by the client with pneumonia.
C) The client with a $PaCO_2$ of 85 could be in serious trouble. The nurse would decide to assess that client first in order to prevent dire consequences for the client.
D) Placement of the client's room can be a decision that is made when considering time management issues; however, the physiologic needs of the clients are the first consideration of the nurse.
Page Ref: 2494
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Assessment
Learning Outcome: 36.2. Analyze the components of clinical decision making.
MNL LO: Analyze the concept of clinical decision making and its application to nursing care.

5) The urgent care clinic nurse is treating a client who is experiencing abdominal pain. The client states, "I think I ate tainted food last night." Which action should the nurse take after the client states that the food was tainted?
A) Ask the client open-ended questions to further assess the situation.
B) Tell the client the healthcare provider does not need to assess the client.
C) Call an ambulance before assessing the client any further.
D) Advise the client to take an antacid.
Answer: A
Explanation: A) In problem solving, the nurse obtains information that clarifies the nature of the problem. This is the first step.
B) The nurse cannot tell the client not to see a healthcare provider before knowing all the essential information.
C) The nurse cannot make decisions such as calling an ambulance before knowing all the essential information.
D) The nurse should not give advice about taking a medication.
Page Ref: 2495, 2501
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Assessment
Learning Outcome: 36.2. Analyze the components of clinical decision making.
MNL LO: Analyze the concept of clinical decision making and its application to nursing care.

6) A client with aspiration pneumonia is diaphoretic, pale, and taking gasping breaths. Which is the priority nursing action?
A) Notify the healthcare provider.
B) Complete a thorough cardiopulmonary assessment.
C) Administer 10 L of oxygen per face mask.
D) Reposition the client to help with breathing.
Answer: B
Explanation: A) The healthcare provider will ask the nurse to identify the reason for the problem and the extent of the problem.
B) The first step in the nursing process is to complete an assessment of the client. The client is indeed experiencing difficulty, but the nurse needs to assess the extent of the need and the reason for the problem before taking action.
C) Administering oxygen could be dangerous to the client in some cases, such as if the client has chronic obstructive pulmonary disease.
D) The client may have simply slipped down in the bed and need repositioning; on the other hand, the client may be in trouble, so making the decision to simply reposition the client without assessment could cause harm.
Page Ref: 2501
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Assessment

Learning Outcome: 36.2. Analyze the components of clinical decision making.
MNL LO: Analyze the concept of clinical decision making and its application to nursing care.

7) The home health nurse is visiting a client who is 2 weeks postoperative from a coronary artery bypass surgery. The client has lost 10 pounds, is continuing to experience pain, and is not eating. Which action should the nurse take?
A) Examine the current interventions for pain relief.
B) Refer the client to social services.
C) Contact Meals on Wheels so that the client will eat.
D) Revise the goals in the current plan of care.
Answer: A
Explanation: A) The nurse evaluates that pain goals for this client have not been met and examines pain relief interventions to determine the problem.
B) Pain relief is a medical issue that is addressed by the nurse and physician, not social services.
C) Contacting Meals on Wheels may not be appropriate if the problem is pain relief.
D) The goal of pain management is pain relief, and that goal would not change; what might change is the interventions to meet the goal.
Page Ref: 2501
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Implementation
Learning Outcome: 36.2. Analyze the components of clinical decision making.
MNL LO: Analyze the concept of clinical decision making and its application to nursing care.

8) The nurse is caring for an older adult client with decreased energy who needs to get up to prevent the development of pressure ulcers. The client is unable to ambulate and wants to be alone. Which action should the nurse take?
A) Notify the healthcare provider of the client's noncompliance.
B) Leave the client alone until ready to get out of bed.
C) Gain knowledge about the client from family to gain compliance.
D) Proceed to get help to get the client out of bed.
Answer: C
Explanation: A) The compliance of the client rests with the nurse, not the physician.
B) It is not an option to leave the client alone and not address some method of ensuring intact skin.
C) The nurse would use knowledge and creativity to think critically about getting the client to cooperate with the medical regimen. For example, the nurse would ask the family to become involved in order to gain compliance.
D) It would not be a good idea to force the client against the client's will; the nurse would use critical thinking to find another way to meet the goal.
Page Ref: 2532
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise and evidence. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Implementation

Learning Outcome: 36.4. Differentiate considerations related to clinical decision making about patients throughout the lifespan.
MNL LO: Analyze the concept of clinical decision making and its application to nursing care.

9) The nurse is caring for an older school-age client who is sleeping when the menu choices for dinner are brought to the room. Which intervention should the nurse use to meet the dietary needs of this client?
A) Wake the child to choose a meal for dinner.
B) Order chicken nuggets because most children like this meal.
C) Ask the dietary worker to come back later.
D) Ask the parents to bring dinner from home for the client.
Answer: C
Explanation: A) The nurse would avoid disturbing the client.
B) The nurse would avoid choosing a meal the client won't eat.
C) Involving children in their own care increases cooperation and decreases anxiety. The nurse would ask the dietary worker to come back later to increase the child's involvement in their own care.
D) If the parents are present, the nurse might ask them if they are comfortable making choices for the child but asking them to bring food in is inappropriate.
Page Ref: 2531
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Implementation
Learning Outcome: 36.4. Differentiate considerations related to clinical decision making about patients throughout the lifespan.
MNL LO: Analyze the concept of clinical decision making and its application to nursing care.

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10) A client asks the student nurse to explain the pathophysiology of diabetes. The student nurse does not know the answer to this question. In which way should the student respond?
A) "I do not know, but I will find out."
B) "You'll have to ask the doctor that question."
C) "Why do you need to know that?"
D) "I do not know."
Answer: A
Explanation: A) The student nurse best exhibits integrity and awareness of self-limits by admitting not knowing the answer but offering to find out and get back to the client. Honesty by the student nurse will build trust with the client.
B) Referring the question to the doctor is also not good ethics; nurses need to continue learning throughout their practice.
C) Questioning the client about the need for the information is defensive and might also be construed as a challenge by the client.
D) Just saying "I don't know" and leaving it at that will make the nurse appear untrustworthy and possibly uncaring
Page Ref: 2494
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Implementation

Learning Outcome: 36.1. Analyze the use of critical thinking skills in nursing.
MNL LO: Analyze the concept of clinical decision making and its application to nursing care.

11) A novice nurse is planning care for an older adult client with a wound infection and systemic blood infection. The nurse completes the plan of care and decides to complete which action to enhance the skill of critical thinking?
A) Discuss the plan with the physician.
B) Request that the client review the plan.
C) Request a review of the plan with the nurse's preceptor.
D) Place the plan on the client's chart.
Answer: C
Explanation: A) The nurse would not seek the opinion of the physician.
B) The nurse would not seek the opinion of the client.
C) Part of the critical thinking process is inquiry, or searching for knowledge or facts. One way the novice nurse can implement inquiry is to discuss the care plan with a more experienced nurse to determine if additional or better interventions need to be added to the care plan.
D) The nurse could put the plan on the chart, but the new nurse would learn more about critical thinking by requesting assistance from a more experienced nurse.
Page Ref: 2494
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Planning
Learning Outcome: 36.2. Analyze the components of clinical decision making.
MNL LO: Analyze the concept of clinical decision making and its application to nursing care.

12) The nurse is taking the time to reflect on a care situation in which a client sustained a cardiac arrest and died. On which areas should the nurse focus when performing this reflection? **Select all that apply.**

A) Things that could have been done differently
B) Gut reactions to the situation
C) Things that were done well
D) Resources that were used at the time
E) Resources that were needed but not available

Answer: A, C, D, E

Explanation: A) Reflection is the action of making sense of occurrences, situations, or decisions by carefully considering the totality of the experience, such as what could have been done differently to achieve better outcomes.

B) A "gut reaction" describes intuition, which is not a part of reflective thinking.

C) Reflection is the action of making sense of occurrences, situations, or decisions by carefully considering the totality of the experience, such as what was done well.

D) Reflection is the action of making sense of occurrences, situations, or decisions by carefully considering the totality of the experience, such as what necessary resources were available.

E) Reflection is the action of making sense of occurrences, situations, or decisions by carefully considering the totality of the experience, such as what necessary resources were not available.

Page Ref: 2497-2498

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: IV.B.7. Identify gaps between local and best practice. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Quality & Safety: Contribute to assessment of outcome achievement. | Nursing Process: Evaluation

Learning Outcome: 36.2. Analyze the components of clinical decision making.

MNL LO: Analyze the concept of clinical decision making and its application to nursing care.

13) A client begins to vomit blood. The nurse immediately measures the blood pressure and prepares to insert a nasogastric tube while directing others to notify the healthcare provider and prepare to perform iced saline lavage. Which features of the Tanner Clinical Judgment Model did this nurse demonstrate? **Select all that apply.**

A) Presencing
B) Noticing
C) Reflecting
D) Interpreting
E) Responding

Answer: B, D, E

Explanation: A) Presencing is being present for a client and engaging in face-to-face contact, which is not part of the Tanner model.

B) The features of the Tanner model include noticing. The nurse noticed that something was wrong with the client.

C) The features of the Tanner model include reflecting. The nurse has not yet reflected on the situation because care is still being provided.

D) The features of the Tanner model include interpreting. The nurse interpreted the cues to gain an understanding of the situation.

E) The features of the Tanner model include responding. The nurse responded by choosing the best course of action.

Page Ref: 2503

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Evaluation

Learning Outcome: 36.3. Outline the components of clinical judgment.

MNL LO: Analyze the concept of clinical decision making and its application to nursing care.

14) The nurse who uses clinical decision making to start CPR on a client is concerned about which other nursing concept?
A) Cognition
B) Perfusion
C) Thermoregulation
D) Acid-base balance
Answer: B
Explanation: A) Cognition is not the nurse's primary concern when CPR is needed.
B) Cardiopulmonary resuscitation (CPR) is used to help restore circulation to major organs, which is a function of perfusion.
C) Thermoregulation is not the nurse's primary concern when CPR is needed.
D) Acid-base balance is not the nurse's primary concern when CPR is needed.
Page Ref: 2492
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Implementation
Learning Outcome: 36.5. Outline the relationship between clinical decision making and other concepts.
MNL LO: Analyze the concept of clinical decision making and its application to nursing care.

Exemplar 36.A The Nursing Process

1) During a health history, a client becomes upset because the nurse is asking many questions. Which response by the nurse is the most appropriate in this situation?
A) "I use the answers to determine your current health needs."
B) "I am sorry the questions disturb you."
C) "I will skip the questions that bother you."
D) "I cannot help you if you do not answer me."
Answer: A
Explanation: A) Many clients may see the health history as an intrusion. The nurse would explain the reason for the questions so the client understands why the questions are being asked.
B) Apologizing to the client is not really appropriate, as the nurse needs information about the client.
C) Skipping questions could cause the nurse to miss areas of client need.
D) Telling the client that the nurse cannot help without answers to the questions is true, but can be seen as a threat and would not be considered a therapeutic response.
Page Ref: 2512
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.C.3. Value the patient's expertise with own health and symptoms. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Communicate information effectively; Listen openly and cooperatively. | Nursing Process: Assessment
Learning Outcome: 36.A. Analyze the nursing process as it relates to clinical decision making. Describe the assessment phase of the nursing process.
MNL LO: Demonstrate understanding of the concept of clinical decision making in the nursing process.

2) The nurse is conducting a class for a group of expectant mothers regarding basic infant care techniques. Which goal will the nurse use to best evaluate the mothers' learning?
A) The mothers will be able to set goals for the next class session.
B) The mothers will be able to pass a written test on how to bathe a newborn infant.
C) The mothers will be able to review the major points of the class.
D) The mothers will be able to provide a return demonstration of a bath on a newborn doll.
Answer: D
Explanation: A) Goals for learning are completed after assessing the knowledge level of the class.
B) Passing a written test does not allow the nurse to determine if the participants are able to complete the skills taught in the class.
C) The nurse would review major points before the end of the class and before evaluating the effectiveness of the teaching.
D) The nursing process identifies needs, plans, goals, and interventions and then evaluates the effectiveness of the interventions. In this case, the evaluation includes having the client demonstrate the ability to care for an infant.
Page Ref: 2521
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 36.A. Analyze the nursing process as it relates to clinical decision making. Describe the planning phase of the nursing process.
MNL LO: Demonstrate understanding of the concept of clinical decision making in the nursing process.

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3) A goal of care for a client with congestive heart failure (CHF) is for serum sodium levels to be within normal limits. Which information documented in the medical record would indicate that the client is not meeting this goal?
A) The client is experiencing dependent edema.
B) The client experiences joint pain.
C) The client is constipated.
D) The client is experiencing wheezing respirations.
Answer: A
Explanation: A) Edema can be a result of a high sodium level, so the nurse who assessed that the client has dependent edema would determine that the goal for normal serum sodium levels is not being met.
B) Joint pain would be relevant for a different goal.
C) Constipation would not be related to a high sodium level.
D) Wheezing would be addressed by a different goal for the client.
Page Ref: 2521
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluating
Learning Outcome: 36.A. Analyze the nursing process as it relates to clinical decision making. Describe the evaluation phase of the nursing process.
MNL LO: Demonstrate understanding of the concept of clinical decision making in the nursing process.

4) The nurse is collecting data about a client's current health status. Which statement would assist in gathering subjective data about the client?
A) "Your eyelid is red and swollen."
B) "Your skin appears to be dry and irritated."
C) "I see that you have bruises on your legs."
D) "Tell me why you have difficulty sleeping."
Answer: D
Explanation: A) Noting that the client has a red and swollen eyelid is an objective observation by the nurse and does not require a response from the client.
B) Noting that the client has dry and irritated skin is an objective observation by the nurse and does not require a response from the client.
C) Noting that the client has bruises on the skin is an objective observation by the nurse and does not require a response from the client.
D) Subjective data is information that the client gives the nurse regarding feelings or happenings. Asking the client to explain why they are having difficulty sleeping will encourage the client to give a subjective response.
Page Ref: 2511
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 36.A. Analyze the nursing process as it relates to clinical decision making. Describe the assessment phase of the nursing process.
MNL LO: Demonstrate understanding of the concept of clinical decision making in the nursing process.

5) An older adult client is experiencing confusion, a temperature of 101.5°F, bruising to the arms and legs, and decreased urine output. The medical diagnosis is a urinary tract infection. Which is the most appropriate nursing diagnosis for this client?
A) Risk for Injury
B) Ineffective Breathing Pattern
C) Activity Intolerance
D) Impaired Memory
Answer: A
Explanation: A) The client has bruising and is confused. A priority nursing diagnosis would focus on client safety. The bruising and confusion place the client at risk for injury related to falls.
B) There is no evidence that the client is having difficulty breathing.
C) Activity intolerance could be a problem; however, the nurse cannot assume that the client has intolerance to activity due to age.
D) Because the client is exhibiting confusion, which is a typical symptom of urinary infection in the elderly, the nurse would choose risk for injury as a priority over memory because it is not possible to assess the client's memory during confusion.
Page Ref: 2513
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Diagnosis
Learning Outcome: 36.A. Analyze the nursing process as it relates to clinical decision making. Describe the diagnosis phase of the nursing process.
MNL LO: Demonstrate understanding of the concept of clinical decision making in the nursing process.

6) An older adult client with heart failure is experiencing activity intolerance due to dyspnea on exertion. Which nursing intervention is a priority for the client?
A) Complete all nursing care at the end of the shift.
B) Delegate care for the client to an aide.
C) Complete all nursing care in the morning.
D) Pace nursing care throughout the shift.
Answer: D
Explanation: A) Waiting until the end of the shift would have the same effect as doing all care in the morning. The key is not to overtax the client's reserves at any time during the shift.
B) Delegating care does not help the client to conserve energy.
C) Completing all care at once can hurt the client's ability to heal by tiring the client too severely.
D) The client with little energy reserve is best served by pacing care throughout the shift to allow for rest periods between activities.
Page Ref: 2523
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 36.A. Analyze the nursing process as it relates to clinical decision making. Differentiate the use of the nursing process in caring for patients across the lifespan.
MNL LO: Demonstrate understanding of the concept of clinical decision making in the nursing process.

7) A client recovering from knee surgery is being prepared to ambulate for the first time. Prior to getting the client up, which action should the nurse take?
A) Ask the client about readiness to walk.
B) Call for a wheelchair to start the process.
C) Conduct a breathing assessment.
D) Evaluate the client's level of pain.
Answer: D
Explanation: A) Most clients are not going to want to get up after surgery, and this intervention is not an option for the client.
B) A wheelchair is not appropriate when getting the client ready to ambulate.
C) Assessing the client's breathing is not relevant to the activity.
D) Before implementing activities, the nurse considers the impact on the client. In this case, ambulation is likely to be painful, so the nurse evaluates the need for pain medication prior to the intervention.
Page Ref: 2511
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 36.A. Analyze the nursing process as it relates to clinical decision making. Describe the implementation phase of the nursing process.
MNL LO: Demonstrate understanding of the concept of clinical decision making in the nursing process.

8) A client who has just been diagnosed with type 2 diabetes mellitus is being instructed by the nurse regarding diet and exercise. Which client statements indicate that further teaching is required? **Select all that apply.**
A) "I should talk to the doctor about an exercise program."
B) "I don't need to watch my diet as long as I take my insulin."
C) "I need to limit the amount of fat in my diet."
D) "I should eat a candy bar when my energy is low."
E) "I will test my blood sugar before meals and at bedtime."
Answer: B, D
Explanation: A) The client should consult the physician regarding starting an exercise program.
B) The nurse would revise the plan and add more teaching if the client believes that no dietary planning is needed as long as the client takes insulin.
C) Limiting fat in the diet is encouraged for this client.
D) The nurse would revise the plan and add more teaching if the client states that candy is necessary for energy.
E) Testing blood sugars before meals and at bedtime is appropriate understanding by the client.
Page Ref: 2527-2528
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 36.A. Analyze the nursing process as it relates to clinical decision making. Describe the evaluation phase of the nursing process.
MNL LO: Demonstrate understanding of the concept of clinical decision making in the nursing process.

9) Which statements accurately reflect the distinction between nursing diagnoses and medical diagnoses? **Select all that apply.**

A) A nursing diagnosis is determined following an assessment and analysis of data gathered only by registered nurses; a medical diagnosis is determined following an assessment and analysis of data gathered only by physicians.

B) A nursing diagnosis changes as the client's responses to an illness or health situation change; a medical diagnosis remains the same as long as the disease process persists.

C) A nursing diagnosis describes a client's physical, sociocultural, psychological, and spiritual responses to an illness or health condition; a medical diagnosis refers to disease processes.

D) A nursing diagnosis considers the etiology of the health problem to give direction to required nursing care; a medical diagnosis does not consider the etiology of the health problem to give direction to medical care.

E) A nursing diagnosis requires the nurses to consider standards and norms as well as cues from clients in discerning an appropriate nursing diagnostic label; a medical diagnosis uses standards and norms only.

Answer: B, C

Explanation: A) Both nursing and medical diagnoses are not only based on information gathered, respectively, by the nurse and physician directly during their assessments, but often include data from other sources.

B) Nursing diagnoses change as the client's response to the illness or situation changes, whereas medical diagnoses remain in place as long as the disease process persists.

C) Nursing diagnoses consider physical, psychosocial, and spiritual responses to illnesses or conditions, whereas medical diagnoses are concerned primarily with disease processes.

D) Both consider etiology (e.g., "Viral Pneumonia" and "Disturbed Sleep Pattern related to frequent coughing").

E) Both nursing and medical diagnoses involve considering client cues as well as standards and norms.

Page Ref: 2513

Cognitive Level: Understanding

Client Need/Sub: Physiological Integrity: Basic Care and Comfort

Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Diagnosis

Learning Outcome: 36.A. Analyze the nursing process as it relates to clinical decision making. Describe the diagnosis phase of the nursing process.

MNL LO: Demonstrate understanding of the concept of clinical decision making in the nursing process.

10) The nurse enters a client's room to evaluate the response to IV pain medication administered by request 20 minutes earlier. The nurse finds the client in the same position as when the medication was administered. The client states, "I do not want to move." The nurse asks the client to rate the current level of pain. Which aspects of the nursing process do these actions represent? **Select all that apply.**

A) Assessment
B) Diagnosis
C) Planning
D) Implementation
E) Evaluation

Answer: A, D, E

Explanation: A) The nurse is engaging simultaneously in an assessment, implementation, and evaluation by observing the client's behavior and asking about current pain level (assessment).
B) The nurse is not diagnosing the client's condition.
C) The nurse is not planning the client's care.
D) The nurse is engaging simultaneously in an assessment, implementation, and evaluation by implementing an aspect of care by following up on the prior pain administration (implementation).
E) The nurse is engaging simultaneously in an assessment, implementation, and evaluation by evaluating the client's response to the earlier pain administration (evaluation).

Page Ref: 2511
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 36.A. Analyze the nursing process as it relates to clinical decision making. Describe the assessment phase of the nursing process.
MNL LO: Demonstrate understanding of the concept of clinical decision making in the nursing process.

11) A construction worker with a chest injury and broken ribs from a fall from a ladder is concerned about caring for the family. Which problem should the nurse make a priority for this client?

A) Risk for infection

B) Ineffective breathing pattern

C) Disturbed sleep pattern

D) Anxiety

Answer: B

Explanation: A) There is no evidence that the client has an injury that increases the risk for infection.

B) Because of the broken ribs, the problem of ineffective breathing pattern would be the priority.

C) There is no evidence that the client has a disturbed sleep pattern.

D) Anxiety would be the client's concern for the family's needs; however, a physical problem would be the priority.

Page Ref: 2513

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Physiological Adaptation

Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Diagnosis

Learning Outcome: 36.A. Analyze the nursing process as it relates to clinical decision making. Describe the diagnosis phase of the nursing process.

MNL LO: Demonstrate understanding of the concept of clinical decision making in the nursing process.

Exemplar 36.B The Nursing Plan of Care

1) The nurse decides to use a standardized plan of care to address a client's health problems. Which criterion differentiates this plan of care from other types? **Select all that apply.**
A) Specifies care for groups of clients
B) Has blank lines
C) Has various shapes connected with lines
D) Has checklists
E) Includes different colors
Answer: A, B, D
Explanation: A) A standardized plan of care specifies the nursing care for groups of patients with common needs.
B) A standardized plan of care has blank lines, or empty spaces to allow the nurse to individualize goals and nursing interventions.
C) A concept map has various shapes connected with lines.
D) A standardized plan of care has checklists.
E) A concept map is constructed using different colors.
Page Ref: 2536
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 36.B. Analyze nursing plans of care as they relate to clinical decision making. Describe the standardized plan type of nursing care plan.
MNL LO: Demonstrate understanding of the concept of clinical decision making when developing and implementing a nursing plan of care for a patient.

2) The nurse is creating a four-column plan of care for a client. For which areas should the nurse prepare to document when creating this care plan? **Select all that apply.**
A) Medications
B) Nursing diagnosis
C) Goals
D) Interventions
E) Evaluation
Answer: B, C, D, E
Explanation: A) Medications are not listed on the plan of care.
B) The column plan of care uses columns to categorize data for each phase of the nursing process. This type of care plan may include four columns, one of which is nursing diagnosis.
C) The column plan of care uses columns to categorize data for each phase of the nursing process. This type of care plan may include four columns, one of which is goals.
D) The column plan of care uses columns to categorize data for each phase of the nursing process. This type of care plan may include four columns, one of which is interventions.
E) The column plan of care uses columns to categorize data for each phase of the nursing process. This type of care plan may include four columns, one of which is evaluation.
Page Ref: 2535
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 36.B. Analyze nursing plans of care as they relate to clinical decision making. Describe the column plan type of nursing care plan.
MNL LO: Demonstrate understanding of the concept of clinical decision making when developing and implementing a nursing plan of care for a patient.

3) The nursing instructor is evaluating a concept map created by a student for a client's plan of care. Which characteristics on the map indicate that the student created the map appropriately? **Select all that apply.**

A) Legend created identifying nursing process phases and client information categories
B) Lines drawn between assessment data and associated nursing diagnoses
C) Different colors used to represent the phases of the nursing process
D) A column entitled "evaluation" located on the outer edge of the document
E) A checklist located at the bottom of the document

Answer: A, B, C

Explanation: A) Approaches to building a concept map include developing a legend for each nursing process phase and one for client information.

B) Approaches to building a concept map include drawing lines between assessment data and associated nursing diagnoses.

C) Approaches to building a concept map include using different colors of paper or Post-It notes to represent the phases of the nursing process.

D) A column entitled "evaluation" is a part of a column nursing care plan.

E) A checklist is a part of a standardized nursing care plan.

Page Ref: 2535

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation

Learning Outcome: 36.B. Analyze nursing plans of care as they relate to clinical decision making. Describe the concept map type of nursing care plan.

MNL LO: Demonstrate understanding of the concept of clinical decision making when developing and implementing a nursing plan of care for a patient.

4) The nurse is selected to participate on a committee to write clinical pathways for a specific set of medical diagnoses. Which are advantages of using this approach when providing client care? **Select all that apply.**
A) Link nursing diagnoses with specific assessment data
B) Sequence the care that is to be given on a particular day
C) Identify interventions, time frames, and expected outcomes
D) List medical treatments to be performed by other providers
E) Provide specific columns for diagnosis, interventions, and evaluation
Answer: B, C, D
Explanation: A) Concept maps link nursing diagnoses with specific assessment data.
B) Clinical pathways sequence the care that must be given on each day during the projected length of stay for the specific type of condition.
C) Clinical pathways include clinical interventions, time frames for completion, usual expectations of response, and expected outcomes.
D) Clinical pathways may include medical treatments to be performed by different types of healthcare providers.
E) Column nursing care plans provide specific columns for diagnosis, interventions, and evaluation.
Page Ref: 2538
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 36.B. Analyze nursing care plans of care as they relate to clinical decision making. Describe the clinical pathway type of nursing care plan.
MNL LO: Demonstrate understanding of the concept of clinical decision making when developing and implementing a nursing plan of care for a patient.

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5) The novice nurse writes a nursing plan of care and includes category headings for each phase of the nursing process, specific and detailed information related to interventions using complete sentences, considers the client's preferences in the chosen interventions, and incorporates preventive and restorative interventions before signing and dating the plan. Which error did the nurse make when creating the plan of care?
A) Should not have used category headings for each phase of the nursing process.
B) Should not have included preventive measures in the care plan until restorative goals were met.
C) Should have included the physician's preferences for care rather than the client's preferences.
D) Should have used approved abbreviations and key words rather than complete sentences.
Answer: D
Explanation: A) When creating a nursing plan of care, the nurse should use category headings related to the nursing process.
B) When creating a nursing plan of care, the nurse should incorporate preventive, health maintenance, and restorative interventions.
C) When creating a nursing plan of care, the nurse should consider the client's preferences when planning care.
D) When creating a nursing plan of care, the nurse should not use complete sentences to communicate ideas and plans unless facility policy dictates otherwise. Approved abbreviations should be used.
Page Ref: 2534
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Planning
Learning Outcome: 36.B. Analyze nursing plans of care as they relate to clinical decision making. Describe the nursing plan of care.
MNL LO: Demonstrate understanding of the concept of clinical decision making when developing and implementing a nursing plan of care for a patient.

6) The nurse is employed on a care area that focuses on the care of clients having knee or hip replacement. Which nursing plan of care is this nurse likely to use most often?
A) Column plan
B) Concept map
C) Standardized plan
D) Clinical pathway
Answer: C
Explanation: A) Column plans are frequently used by novice nurses when more details are needed or to stimulate critical thinking.
B) Concept maps are frequently used by novice nurses when more details are needed or to stimulate critical thinking.
C) The orthopedic unit has a high volume of clients who are undergoing common surgical procedures. Therefore, this unit would likely use standardized plans that specify nursing care for groups of clients with common needs.
D) Clinical pathways are also used for clients with common, predictable health outcomes. However, they need to be ordered by the healthcare provider.
Page Ref: 2536
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.B.3. Base individualized care plan on patient values, clinical expertise and evidence. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Planning
Learning Outcome: 36.B. Analyze nursing plans of care as they relate to clinical decision making. Describe the standardized plan type of nursing care plan.
MNL LO: Demonstrate understanding of the concept of clinical decision making when developing and implementing a nursing plan of care for a patient.

Exemplar 36.C Prioritizing Care

1) The nurse is preparing to provide care to a group of clients. On which specific areas should the nurse focus in order to prioritize the clients' care needs? **Select all that apply.**
A) Asking if any clients have complex issues
B) Noting number of licensed staff assigned for the shift
C) Noting time when the attending physicians make rounds
D) Identifying clients with specific medication times
E) Noting which clients have particular safety needs
Answer: A, D, E
Explanation: A) Setting priorities for nursing care always begins with assessment. Assessment includes making observations and asking questions to gather information necessary to make decisions. Helpful assessment data include knowing which clients have complex care issues.
B) The number of licensed staff is not as important as knowing the number of unlicensed assistive personnel to whom the nurse can delegate client care activities.
C) The time when attending physicians make rounds is not usually part of the criteria when prioritizing client care needs.
D) Setting priorities for nursing care always begins with assessment. Assessment includes making observations and asking questions to gather information necessary to make decisions. Helpful assessment data include knowing if any clients have particular medication times.
E) Setting priorities for nursing care always begins with assessment. Assessment includes making observations and asking questions to gather information necessary to make decisions. Helpful assessment data include knowing if any clients have safety issues that should be addressed.

Page Ref: 2542
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 36.C.2. Analyze prioritizing care as it relates to clinical decision making. Describe methods of identifying what to prioritize.
MNL LO: Demonstrate understanding of the concept of clinical decision making when prioritizing care for a patient.

2) The nurse is prioritizing care for a client with several problems. List the order in which the nurse should address the client's needs.
A) Bleeding through nasogastric tube
B) Audible wheezes
C) Not understanding how to complete the menu
D) Requesting medication for arthritis pain
E) Dyspnea
F) Asking questions about teaching provided the other day
Answer: B, E, A, D, F, C
Explanation: The nurse's priority should follow the ABCs, or airway, breathing, and circulation. Audible wheezes could indicate an obstruction and should be attended to first. Dyspnea indicates a problem with breathing and should be addressed next. Bleeding could impact circulation and should be addressed third. Pain control should be addressed fourth. Reinforcement of teaching can occur fifth and helping with menu completion can occur last.
Page Ref: 2542
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 36.C. Analyze prioritizing care as it relates to clinical decision making. Describe methods of identifying what to prioritize.
MNL LO: Demonstrate understanding of the concept of clinical decision making when prioritizing care for a patient.

3) The nurse is prioritizing care for a client based on identified problems. If following Maslow's hierarchy of needs, list the order in which the nurse should provide care to the client.
A) Fatigue
B) Anxiety
C) Alteration in perfusion
D) Self-care deficit
E) Deficient knowledge
F) Diarrhea
Answer: C, F, D, B, A, E
Explanation: High-priority problems should be addressed first. This means the problem with perfusion would be the first priority. Medium-priority problems should be addressed next, in order of the impact on physiologic processes. Diarrhea would be a priority over self-care deficit; however, self-care deficit would be a priority over anxiety. Low-priority problems would be addressed last, again in order of physiologic impact. Fatigue would be a priority over deficient knowledge.
Page Ref: 2542
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.3. Base individualized care plan on patient values, clinical expertise, and evidence. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 36.C. Analyze prioritizing care as it relates to clinical decision making. Describe methods of identifying what to prioritize.
MNL LO: Demonstrate understanding of the concept of clinical decision making when prioritizing care for a patient.

4) The nurse is prioritizing care needed for a group of clients according to urgency. Which care should the nurse identify as being medium priority? **Select all that apply.**
A) Instructing on changing ostomy appliance
B) Performing passive range of motion every 4 hours
C) Removing splints and providing complete skin care every 2 hours
D) Administering 2 units of fresh frozen plasma
E) Performing endotracheal suction
Answer: B, C
Explanation: A) Instructing on ostomy appliance changes is a low-priority intervention.
B) Medium-priority interventions are those that would not cause a life-threatening situation if performed later throughout the shift. These interventions include passive range of motion exercises.
C) Medium-priority interventions are those that would not cause a life-threatening situation if performed later throughout the shift. These interventions include removing splints for skin care.
D) Administering fresh frozen plasma is a critical intervention because if it is not performed, the client's health status could quickly deteriorate.
E) Endotracheal suctioning is a critical intervention because if it were not done, the client's health status could quickly deteriorate.
Page Ref: 2543
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 36.C. Analyze prioritizing care as it relates to clinical decision making. Describe methods of identifying what to prioritize.
MNL LO: Demonstrate understanding of the concept of clinical decision making when prioritizing care for a patient.

5) The nurse is prioritizing care activities that are to be completed for a group of clients. From highest to lowest priority, list the order in which the nurse should complete the listed activities.
A) Measure blood pressure before administering antihypertensive medication.
B) Request dietary consult for gluten-free diet.
C) Remove an intravenous access device infusing chemotherapy.
D) Change a dressing on an arm wound.
E) Call a family member to bring in shoes.
F) Ambulate to the bathroom using a walker.
Answer: C, A, D, F, B, E
Explanation: The highest-priority action would be to remove an intravenous access device infusing chemotherapy because this could lead to significant tissue damage. Measuring blood pressure before administering antihypertensive medication is the next priority because this could be a timed intervention. Changing a dressing on an arm wound can occur anytime throughout the shift. Ambulating using a walker to the bathroom can be delegated to unlicensed assistive personnel. Requesting a dietary consult for gluten-free diet can also be done at any time and does not have a specific degree of urgency. Contacting family to bring in shoes can be completed at the end of the shift or delayed to the next shift.
Page Ref: 2543
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 36.C. Analyze prioritizing care as it relates to clinical decision making. Describe methods of identifying what to prioritize.
MNL LO: Demonstrate understanding of the concept of clinical decision making when prioritizing care for a patient.

6) The nurse is preparing to triage victims of a train derailment who are being transported to the emergency department. Which victims would need immediate care? **Select all that apply.**
A) Holding broken arm, sitting in a chair
B) Respiratory rate of 8 and irregular
C) Bleeding from fractured limb with a blood pressure of 78/40 mmHg
D) Bleeding from superficial facial wounds and talking to family
E) Walking with a slight limp, asking for something to drink
Answer: B, C
Explanation: A) Holding a broken arm sitting in a chair would be urgent.
B) A respiratory rate of 8 would be emergent.
C) A blood pressure of 78/40 mmHg would be emergent
D) Bleeding from superficial facial wounds while talking with family would be urgent.
E) The client walking with a limp and asking for something to drink would be nonurgent.
Page Ref: 2544
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 36.C. Analyze prioritizing care as it relates to clinical decision making. Describe various processes of categorizing priorities.
MNL LO: Demonstrate understanding of the concept of clinical decision making when prioritizing care for a patient.

7) After receiving the morning report, the nurse prioritizes care needed by several clients. Which factors should the nurse keep in mind when creating this priority list? **Select all that apply.**

A) Client condition
B) Safety
C) Time available
D) Client preferences
E) Nurse preferences

Answer: A, B, C, D

Explanation: A) A change in client status may require reevaluating priorities and changing the planned order of interventions.
B) Factors that influence prioritization include safety factors.
C) Factors that influence prioritization include available time.
D) Factors that influence prioritization include client preferences.
E) Nurse preferences are often set aside when creating a priority list of care needed by clients.

Page Ref: 2544

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning

Learning Outcome: 36.C. Analyze prioritizing care as it relates to clinical decision making. Outline factors to consider when prioritizing care.

MNL LO: Demonstrate understanding of the concept of clinical decision making when prioritizing care for a patient.

8) The nurse manager is concerned that a staff nurse is having difficulty prioritizing client care needs. Which observations caused the manager to have this concern? **Select all that apply.**
A) Relying on another nurse's assessment
B) Reviewing the medication administration record
C) Not completing an assessment
D) Doing easiest tasks first
E) Asking unlicensed assistive personnel to perform complicated care
Answer: A, C, D, E
Explanation: A) Obtaining assessment data from another nurse can provide insight and give a picture of how a client has been during the previous shift; however, using only this information to set priorities may negatively impact client outcomes.
B) Reviewing the medication administration record does not negatively impact prioritization.
C) Failing to complete an assessment can cause the nurse to miss important and necessary information when setting priorities.
D) Completing easy tasks before doing important, necessary tasks does not make good, professional common sense.
E) Inappropriate delegation may result in the nurse having to do an intervention over or may even result in harm to the client.
Page Ref: 2548
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 36.C. Analyze prioritizing care as it relates to clinical decision making. Summarize pitfalls of prioritization.
MNL LO: Demonstrate understanding of the concept of clinical decision making when prioritizing care for a patient.

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9) For which reason should nurses prioritize care?
A) Nurses need to plan how to accomplish all activities within one shift.
B) Nurses can accomplish more if they perform the easiest or fastest interventions first.
C) Nurses should perform interventions related to client preferences early in the shift.
D) Nurses only have a limited amount of time to perform nursing interventions.
Answer: D
Explanation: A) It will likely not be possible for a nurse to plan how to accomplish all activities within one shift.
B) Nurses often accomplish less and are more stressed if they perform the easiest or fastest interventions first.
C) Nurses should consider client preferences for all interventions regardless of the time the intervention is completed.
D) Nurses only have a limited amount of time to perform nursing interventions. By prioritizing care, nurses can ensure that high-priority interventions are completed first, followed by medium-priority and then low-priority interventions as time allows.
Page Ref: 2548
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Planning
Learning Outcome: 36.C. Analyze prioritizing care as it relates to clinical decision making. Describe the need for nurses to prioritize care.

MNL LO: Demonstrate understanding of the concept of clinical decision making when prioritizing care for a patient.

***Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e* (Pearson)**
Module 37 Collaboration

The Concept of Collaboration

1) The home health nurse is planning care for an adult client who is being discharged from the hospital after experiencing complications of diabetes mellitus. The client requires an extensive dressing change twice per day, help with activities of daily living, and comprehensive education. To ensure these needs are met, the nurse is coordinating home visits from aides and therapists. Which role is the nurse assuming by coordinating this client's care?
A) Health educator
B) Case manager
C) Client advocate
D) Health promoter
Answer: B
Explanation: A) Although the client requires education, the home health nurse's primary role is not that of health educator.
B) A case manager is responsible for ensuring that clients receive fiscally sound, appropriate care in the best setting. Part of the case manager's duties include identifying which services a client will require post discharge, locating providers of these services, and coordinating visits from these providers. In this scenario, the home health nurse is assuming the role of case manager.
C) Although case managers often engage in client advocacy this task accounts for just a portion of the nurse's duties in this scenario.
D) Although case managers often engage in health promotion activities, this task accounts for just a portion of the nurse's duties in this scenario.
Page Ref: 2555
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.1. Describe own strengths, limitations, and values in functioning as a member of a team. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; collaborate and work cooperatively with others. | Nursing Process: Planning
Learning Outcome: 37.1. Describe the nurse's role as a collaborative member of the healthcare team.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

2) The nurse is discussing follow-up care with a client who is being discharged. The client and family cross their arms and state angrily that the care team's suggestions are not acceptable. Which response by the nurse is appropriate?
A) "We will leave you alone to discuss your options."
B) "We only want what's best for you."
C) "Let's discuss other options that might work well for you and your family."
D) "Perhaps you did not understand the recommendations."
Answer: C
Explanation: A) Leaving the room might lead the client and family to feel abandoned by the healthcare team.
B) Stating that the team "only wants what is best" sends the message that the client does not know what is best, when, in fact, a well-informed client does know what is best and should be able to make the correct choice.
C) Major objectives of interprofessional collaborative practice include providing client-directed, client-centered care; improving client and family satisfaction with care; and promoting mutual respect, communication, and understanding between the client and members of the healthcare team. Of the choices listed here, the response that best supports achievement of these objectives is "Let's discuss other options that might work well for you and your family."
D) Suggesting that the client and family do not understand the recommendations may be interpreted as demeaning, even if it is true.
Page Ref: 2559
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.7. Discuss effective strategies for communicating and resolving conflict. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Resolve conflicts. | Nursing Process: Implementation

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Learning Outcome: 37.4. Summarize the benefits and nature of interprofessional collaborative practice.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

3) The nurse is preparing for the discharge of a client who will require physical therapy (PT) for rehabilitation following a total knee replacement. After reading the healthcare provider's order for PT, which action should the nurse take next?
A) Set up outpatient appointments for the client with the hospital's PT department
B) Call home health and schedule a therapist to visit the client's home for PT
C) Inform the client about the settings in which PT may occur and have the client choose the venue
D) Teach the client's family the exercises that will be included in the client's PT regimen
Answer: C
Explanation: A) The nurse would not refer the client for outpatient therapy unless the client specifically requested this form of therapy.
B) The nurse would not schedule home PT unless the client specifically requested this form of therapy.
C) Major objectives of interprofessional collaborative practice include providing client-directed, client-centered care; improving client and family satisfaction with care; and promoting mutual respect, communication, and understanding between the client and members of the healthcare team. Of the choices listed, the option that best supports achievement of these objectives is informing the client about the settings in which PT may occur and having the client choose the desired venue.
D) Because the client requires therapy that must be performed by a professional physical therapist, providing teaching about exercises that will be included in the client's PT regimen encroaches on the expertise of another healthcare professional.
Page Ref: 2559
Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.C.2. Appreciate importance of intra- and interprofessional collaboration. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; collaborate and work cooperatively with others. | Nursing Process: Implementation
Learning Outcome: 37.4. Summarize the benefits and nature of interprofessional collaborative practice.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

4) The nurse is caring for a client with rheumatoid arthritis who expresses the desire to remain active as long as possible. In order for the client to meet this goal, which action should the nurse take?
A) Teach the client about nutrition and joint exercises.
B) Ask the client about the reasons for this goal.
C) Tell the client that activity limitations are inevitable with rheumatoid arthritis.
D) Provide referrals to other professionals who can help the client meet this goal.
Answer: D
Explanation: A) The nurse can provide the client with some teaching about nutrition and joint exercises but cannot go into the depth that this client would require.
B) Asking the client the reason for the desired goal is irrelevant to the situation.
C) A client with a chronic disease should not be told there is no hope but should be helped toward reaching desired goals.
D) When a client expresses the desire to live as normally as possible, the nurse should refer the client to professionals who can help the client meet that goal.
Page Ref: 2558
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.C.2. Appreciate importance of intra- and interprofessional collaboration. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; collaborate and work cooperatively with others. | Nursing Process: Implementation
Learning Outcome: 37.4. Summarize the benefits and nature of interprofessional collaborative practice.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

5) The nurse is working as the designated leader of a group of healthcare providers in a community clinic setting. The team members are working to decrease the number of adolescent pregnancies in the community. They have defined the problem and are now focusing on objectives and considering various viewpoints presented by the group. The nurse is tasked with helping the team stay focused in order to address the defined problem. Which competency of collaboration does this describe?
A) Values and ethics
B) Roles and responsibilities
C) Teams and teamwork
D) Communication
Answer: C
Explanation: A) Members of the interprofessional team have a duty to work with other professionals and the client in a mutually respectful manner that promotes trust and supports the shared goals of quality and safety. This, however, is not the competency that the nurse is demonstrating.
B) Each member of the interprofessional team should be committed to understanding and appreciating the role and scope of practice of other members of the team. However, this is not the competency that the nurse is demonstrating.
C) Teams depend on each member to interact with other members toward the goal of client care and to put team goals before individual goals. Members should understand the role and scope of practice of each team member as well as their own scope of practice. When addressing client care or concerns, all team members should provide discipline-specific input, followed by discussion and shared decision making. Team members should also acknowledge each other and work together to resolve areas of conflict and disagreement. This is the competency that the nurse is tasked to complete.

D) Communication occurs when two or more parties are committed to understanding each other's professional roles and appreciating each other as individuals. Although mutual respect, trust, and communication may indeed be part of this team's collaborative effort, the situation described here is most clearly illustrative of the competency of teams and teamwork.
Page Ref: 2558
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.C.2. Appreciate importance of intra- and interprofessional collaboration. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; collaborate and work cooperatively with others. | Nursing Process: Planning
Learning Outcome: 37.3. Identify competencies necessary for successful collaboration.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

6) The nurse managers in a community hospital have been charged with reviewing the job descriptions of unlicensed assistive personnel (UAP), and they have questions about the delegation of certain client care activities to UAP by nurses. To which group, organization, or individual would the committee members direct their questions to obtain definitive answers about the parameters of nurse delegation to UAP?
A) The hospital's Chief Nursing Officer
B) The hospital's Chief Executive Officer
C) The state board of nursing
D) The American Nurses Association
Answer: C
Explanation: A) The parameters of nurse delegation to UAP are not identified by the hospital's Chief Nursing Officer.
B) The parameters of nurse delegation to UAP are not identified by the hospital's Chief Executive Officer.
C) The parameters of nurse delegation to UAP are delineated by state boards of nursing.
D) The parameters of nurse delegation to UAP are not identified by the American Nurses Association.
Page Ref: 2555
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.C.2. Appreciate importance of intra- and interprofessional collaboration. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; collaborate and work cooperatively with others. | Nursing Process: Implementation
Learning Outcome: 37.1. Describe the nurse's role as a collaborative member of the healthcare team.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

7) An experienced nurse is delivering a presentation to a group of nursing students about the importance of collaboration in the healthcare environment. Which benefits of collaboration should the nurse discuss in the presentation? **Select all that apply.**
A) Improved client outcomes
B) Reduction in duplication of healthcare services
C) Increased overall cost of healthcare services
D) Decreased client morbidity and mortality
E) Higher level of job satisfaction
Answer: A, B, D, E
Explanation: A) Collaboration in healthcare among clients, family members, caregivers, and communities leads to improved client outcomes.
B) Collaboration in healthcare among clients, family members, caregivers, and communities leads to a reduction in the duplication of healthcare services.
C) Collaborative efforts have been found to decrease, rather than increase, the overall cost of healthcare services.
D) Collaboration in healthcare among clients, family members, caregivers, and communities leads to a decrease in client morbidity and mortality.
E) An increase in sense of autonomy has been linked to greater job satisfaction among nurses.
Page Ref: 2556, 2559
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.C.2. Appreciate importance of intra- and interprofessional collaboration. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; collaborate and work cooperatively with others. | Nursing Process: Implementation
Learning Outcome: 37.4. Summarize the benefits and nature of interprofessional collaborative practice.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

8) Which barrier to effective nurse-physician collaboration has persisted over time?

A) The view among the general population that nurses' contributions to client care are less important to health and well-being than physicians' contributions

B) Nurses' and physicians' perceptions of inequity in their roles, with nurses assuming a subservient role and physicians assuming leadership and a superior role in healthcare settings

C) A general lack of education among health professionals about the ways in which nurse-physician collaboration improves healthcare quality

D) A lack of published evidence regarding the effectiveness of collaborative efforts among and between nurses and physicians

E) A lack of support at the federal level for efforts to improve healthcare among the general population through increased nurse-physician-client collaboration

Answer: B

Explanation: A) Evidence does not suggest that the general population views nurses' contributions to client care as less important than physicians' contributions.

B) Over the years, a primary barrier to effective nurse-physician collaboration has been nurses' and physicians' perceptions of inequity in their roles, with nurses assuming a subservient role and medical providers perceiving their role to be superior in the provision of healthcare services.

C) Because health professionals are educated about the benefits of collaborative practice, this is not a barrier to collaboration.

D) Because evidence has documented the effectiveness of collaboration in improving client outcomes, this is not a barrier to collaboration.

E) The federal government, as evidenced in particular by the Healthy People initiative, has promoted collaborative efforts among clients, nurses, physicians, other healthcare providers, and the larger community to improve the overall health of the U.S. population.

Page Ref: 2558

Cognitive Level: Understanding

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: II.C.2. Appreciate importance of intra- and interprofessional collaboration. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; collaborate and work cooperatively with others. | Nursing Process: Assessment

Learning Outcome: 37.3. Identify competencies necessary for successful collaboration.

MNL LO: Analyze the concept of collaboration and its application to nursing care.

9) A client with type 1 diabetes mellitus has developed an open sore on the shin and is having trouble meeting daily goals for exercise. The client is scheduled for discharge in a couple of days. When planning for this client's continued care, who will the nurse notify regarding the client's post discharge needs?
A) The pharmacy
B) The case manager
C) The occupational therapist
D) The physical therapist
Answer: B
Explanation: A) The pharmacy would not be a necessary part of the care team at this time.
B) The client's needs and progress have changed, so the nurse should contact the case manager to coordinate appropriate modifications in the client's post discharge care plan.
C) An occupational therapist mainly deals with upper body areas that require rehabilitation, and the client currently does not require such assistance.
D) A physical therapist may be needed, but the nurse would best coordinate care by notifying the case manager.
Page Ref: 2555
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; collaborate and work cooperatively with others. | Nursing Process: Implementation

Learning Outcome: 37.1. Describe the nurse's role as a collaborative member of the healthcare team.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

10) The nurse is discussing the plan of care with a client who is preparing for discharge. The client has a strong objection to portions of the plan of care. The nurse recognizes that there is a conflict. Which response by the nurse indicates an understanding of the client's position and a willingness to collaborate regarding the discharge plan?
A) "You are not being cooperative in your plan of care."
B) "This plan of care was ordered by the physician."
C) "Let's talk about your objections and possible solutions or alternatives."
D) "I will ask your family to help convince you that this plan of care is best."
Answer: C
Explanation: A) Telling a client that they are being uncooperative is likely to anger the client and cause further conflict.
B) Telling the client that these orders were made by the physician continues the conflict and brings the physician into it.
C) The nurse attempts to resolve the conflict with the client by listening to the client's concerns and then negotiating with the client. This action helps build the client's trust in the medical team.
D) The nurse would not want to include the client's family in the conflict and cause problems between family members.
Page Ref: 2560, 2562-2563
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.7. Discuss effective strategies for communicating and resolving conflict. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Resolve conflicts. | Nursing Process: Implementation

Learning Outcome: 37.5. Analyze aspects of conflict prevention and management.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

11) The nurse who is caring for an adult client in the intensive care unit (ICU) is given a verbal prescription by a first-year medical resident. The nurse determines that the best course of action is to check with the attending healthcare provider before implementing the prescription. For which reason is the nurse experiencing conflict regarding this situation?
A) The resident seems unsure of the prescription.
B) The nurse only takes prescription orders from attending healthcare providers.
C) The nurse does not like first-year residents.
D) The nurse may not trust the resident to make the best care decisions.
Answer: D
Explanation: A) There is no evidence here that the resident is unsure of the order given.
B) Residents can give orders, preferably written, but the nurse is wise to confirm the order with the managing physician.
C) The nurse may not like residents, but that is not a reason to question their orders.
D) This type of conflict is most likely related to a lack of trust in the resident on the part of the nurse. Nurses who work in critical care learn to validate orders given by residents because mistakes can take a client's life.
Page Ref: 2560
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.7. Discuss effective strategies for communicating and resolving conflict. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Resolve conflicts. | Nursing Process: Implementation
Learning Outcome: 37.5. Analyze aspects of conflict prevention and management.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

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12) A staff nurse learns that a close family member has been diagnosed with terminal cancer and the client is assigned to the nurse for care. The outgoing nurse states that the client is very demanding and complains a lot. Which action by the oncoming staff nurse is appropriate?
A) Discuss the situation with the charge nurse.
B) Resolve to refrain from reacting negatively to the client.
C) Tell the client to change the behavior.
D) Ask the healthcare provider to help control the client.
Answer: A
Explanation: A) The best action to prevent conflict would be to explain the personal situation to the charge nurse and ask for a reassignment.
B) The nurse can resolve to not react to the client, but the nurse should have the presence of mind to understand that the client's personal ability to cope is impaired.
C) It would not be appropriate to confront the client at this time.
D) The nurse should not ask anyone other than the charge nurse to intervene.
Page Ref: 2561
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.7. Discuss effective strategies for communicating and resolving conflict. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Resolve conflicts. | Nursing Process: Implementation
Learning Outcome: 37.5. Analyze aspects of conflict prevention and management.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

13) During a staff meeting, the manager announces that nurses should not criticize and make fun of other nurses or there will be repercussions. Which attitude is the manager demonstrating about bullying?
A) Leniency
B) Consistency
C) Threatening
D) Zero tolerance
Answer: D
Explanation: A) Stating that repercussions should be expected if bullying occurs is not demonstrating leniency.
B) The nurse manager is not demonstrating consistency regarding bullying because the action to be taken if it occurs has not been shared with the group.
C) The nurse manager is not threatening the staff.
D) The nurse manager is explaining a zero-tolerance attitude toward bullying.
Page Ref: 2565
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.7. Discuss effective strategies for communicating and resolving conflict. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Resolve conflicts. | Nursing Process: Assessment
Learning Outcome: 37.5. Analyze aspects of conflict prevention and management.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

14) The nurses in the emergency department (ED) and the staff nurses on the neurology unit are experiencing conflict. The ED nurses are not pleased with the amount of time it takes for the neurology unit's admitting nurse to receive face-to-face handoff communication for clients who are being admitted to that unit. Which type of conflict is being experienced by these nurses?
A) Intrapersonal conflict
B) Interpersonal conflict
C) Intergroup conflict
D) Interorganizational conflict
Answer: C
Explanation: A) Intrapersonal conflict describes stress or tension within the individual that results from real or perceived pressure associated with incompatible expectations.
B) Interpersonal conflict is characterized by conflict between individuals (rather than service areas as in this situation).
C) Because the conflict involves two teams of nurses from different units, it would be classified as intergroup conflict. This conflict is likely driven by each team's wish to provide quality care for its clients in a context of limited resources or lack of role clarity.
D) Interorganizational conflict typically involves competition between two organizations existing in one market.
Page Ref: 2560
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.7. Discuss effective strategies for communicating and resolving conflict. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Resolve conflicts. | Nursing Process: Assessment
Learning Outcome: 37.5. Analyze aspects of conflict prevention and management.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

15) A community hospital wants to implement a labor—delivery—recovery—postpartum unit to replace the labor and delivery and mother/baby units. The nurses who work on the mother/baby unit are concerned they will not be able to care for laboring mothers and may lose their jobs. The nurse manager for both units supports the plan for an integrated unit, reports that jobs will not be lost, and involves the team members in the planning process, which includes cross-training all nursing staff. Based on the information presented, what causes of conflict may occur despite the nurse manager's effort for a smooth transition? **Select all that apply.**
A) Mistrust
B) Communication
C) Ambiguous role expectations
D) Workflow
E) Work environment
Answer: B, C, D, E
Explanation: A) There is no evidence that the nurses mistrust the plans for the new care area.
B) Factors that influence interpersonal conflict include communication.
C) Since the unit is being redesigned and staff are being cross-trained, there is a risk for ambiguous role expectations.
D) A change in the unit's structure can create conflict with the workflow.
E) A change in the unit's structure can create conflict within the work environment.
Page Ref: 2560
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.7. Discuss effective strategies for communicating and resolving conflict. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Resolve conflicts. | Nursing Process: Planning
Learning Outcome: 37.5. Analyze aspects of conflict prevention and management.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

16) A nurse manager overhears two staff nurses talking about a third nurse, who has the day off. The two nurses are making unflattering comments regarding the third nurse in front of several other nurses who work on the unit. The nurse manager discreetly asks to speak to the two nurses in private and states, "This behavior isn't OK, especially in a hospital like ours with a 'zero-tolerance policy.' If you have an issue with another nurse, please deal with that nurse directly. If you'd like me to help you with this, please let me know, and the four of us can meet." The nurse manager's behavior modeled strategies for dealing with which type of workplace conflict?
A) Intergroup conflict
B) Sexual harassment
C) Horizontal violence
D) Intrapersonal conflict
Answer: C
Explanation: A) Intergroup conflict involves conflict between teams that are in competition with each other, which is not the case in this scenario.
B) There is not enough information presented to know whether sexual harassment was an issue.
C) In quietly and respectfully confronting the two nurses about their disparaging comments, the nurse manager modeled strategies for dealing with horizontal violence (HV). HV is a form of workplace bullying that involves aggressive acts committed against a nurse by one or more nursing colleagues. The director's positive steps to address HV included reminding the nurses about the hospital's "zero-tolerance" attitude toward bullying; demonstrating to the other nurses that the issue of bullying is taken seriously; and offering to help the nurses appropriately address with their colleague the behavior that prompted the disparaging comment.
D) Intrapersonal conflict refers to conflict within an individual, which is not necessarily evident in this scenario.

Page Ref: 2563
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.7. Discuss effective strategies for communicating and resolving conflict. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Resolve conflicts. | Nursing Process: Implementation
Learning Outcome: 37.6. Describe the effects of incivility in the workplace.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

17) A case manager assembles a team of healthcare professionals, including a client's primary healthcare provider, physical therapist, and social worker, for the purpose of collaborative discharge planning and decision making. Which type of team did the case manager assemble?
A) Intradisciplinary team
B) Interprofessional team
C) Interorganizational team
D) Management team
Answer: B
Explanation: A) An intradisciplinary team includes members of the same profession.
B) Interprofessional teams include professionals of varied backgrounds who share decision making. This is the type of team the case manager assembled.
C) An interorganizational team includes members from more than one organization, and the scenario doesn't mention whether multiple organizations are involved.
D) A management team is an executive-level team that runs the day-to-day operations of a department or organization.
Page Ref: 2553
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.C.2. Appreciate importance of intra- and interprofessional collaboration. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Practice: Learn continuously, derive meaning from others' work, and learn from experience within the healthcare community. | Nursing Process: Planning
Learning Outcome: 37.4. Summarize the benefits and nature of interprofessional collaborative practice.

MNL LO: Analyze the concept of collaboration and its application to nursing care.

18) A school-age client is admitted to the pediatric intensive care unit (PICU), unconscious and with multiple traumatic injuries, after a skateboard accident that included a closed head injury. Many health professionals are involved in the client's care, and the scene is chaotic. The client's parents are extremely anxious and want to know what is happening. The case manager asks for an interprofessional team meeting to speak with the client's parents. For which reason did the case manager call for the meeting?
A) Allow for each specialty to practice independently
B) Share and evaluate information for care planning and implementation, and to prevent priority conflicts, redundancy, and omissions in care
C) Allow the primary healthcare provider to make all decisions regarding the client's care
D) Prevent the client's parents from trying to change the plan of care
Answer: B
Explanation: A) Interprofessional meetings are not used to allow for each specialty to practice independently.
B) Interprofessional collaboration engages each professional's contribution to joint care planning, implementation, and accomplishment of client goals, often with less redundancy, more efficiency, and fewer care omissions.
C) Interprofessional meetings are not used to allow the primary healthcare provider to make all decisions regarding the client's care.
D) Interprofessional meetings are not called to prevent family members from providing input regarding the plan of care. The parents of a minor child should be involved in all aspects of care and decision making.
Page Ref: 2554
Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.C.3. Value the perspectives and expertise of all health team members. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Practice: Learn continuously, derive meaning from others' work, and learn from experience within the healthcare community. | Nursing Process: Planning
Learning Outcome: 37.4. Summarize the benefits and nature of interprofessional collaborative practice.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

19) In arranging community services for a client who is diagnosed with schizophrenia, the nurse case manager discusses options with the assertive community treatment (ACT) team. Which team disciplines should the nurse expect will be part of the client's ACT interprofessional team?
A) Psychiatrists, nurses, social workers, employment counselors
B) Speech pathologists, occupational therapists, nurses, physicians
C) Teachers, school administrators, psychiatrists, nurses
D) Transportation providers, nurses, physicians, social workers
Answer: A
Explanation: A) ACT provides mental health and support services in the community for individuals with serious mental illness, such as schizophrenia or bipolar disorder, to promote optimal functioning at home and within the community. Professionals participating in an individual client's care team may include psychiatrists, psychologists, social workers, pharmacists, advanced practice nurses, employment counselors, and peer support specialists.
B) A client with schizophrenia would not require speech pathology remediation or occupational therapy.
C) A client with schizophrenia would not require teacher assistance or school administration intervention.
D) Although transportation providers may be used, they would not be part of the ACT team.
Page Ref: 2559
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Practice: Learn continuously, derive meaning from others' work, and learn from experience within the healthcare community. | Nursing Process: Planning
Learning Outcome: 37.4. Summarize the benefits and nature of interprofessional collaborative practice.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

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20) A home healthcare nurse is planning care for an older adult client. Which interprofessional program would best support the needs of an older adult client within the community? **Select all that apply.**

A) Assertive community treatment (ACT)
B) YMCA
C) Programs of All-Inclusive Care for the Elderly (PACE)
D) Transportation services
E) Meals on Wheels

Answer: C, D

Explanation: A) ACT is a mental health support and treatment program, not an interprofessional eldercare program.

B) The YMCA is a fitness facility, not an interprofessional eldercare program.

C) Interprofessional teams are used in many settings outside the hospital, including schools, workplaces, and long-term care facilities. PACE supports and facilitates the provision of numerous services for older adults.

D) Interprofessional teams are used in many settings outside the hospital, including schools, workplaces, and long-term care facilities. PACE supports and facilitates the provision of numerous services for older adults. Transportation services may be a part of the PACE program.

E) Meals on Wheels provides a service to older adult clients but is not an interprofessional program.

Page Ref: 2559

Cognitive Level: Analyzing

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: II.C.2. Appreciate importance of intra- and interprofessional collaboration. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Practice: Learn continuously, derive meaning from others' work, and learn from experience within the healthcare community. | Nursing Process: Planning

Learning Outcome: 37.4. Summarize the benefits and nature of interprofessional collaborative practice.

MNL LO: Analyze the concept of collaboration and its application to nursing care.

21) Which quality exists when team members value the contributions and knowledge of each team member and treat all members as equals?
A) Trust
B) Conflict management
C) Mutual respect
D) Effective communication
Answer: C
Explanation: A) Trust occurs when an individual is confident in the actions of another individual.
B) Conflict management involves addressing, containing, and resolving disagreements among team members in a constructive way.
C) Mutual respect occurs when team members value the contributions and knowledge of each team member and treat all members as equals. Respect also includes acknowledging the uniqueness and differing views that each member and profession brings to the team.
D) Effective communication involves sharing information and ideas both clearly and in a way that demonstrates respect and appreciation for other team members.
Page Ref: 2556
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.C.3. Value the perspectives and expertise of all health team members. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Practice: Learn continuously, derive meaning from others' work, and learn from experience within the healthcare community. | Nursing Process: Assessment
Learning Outcome: 37.3. Identify competencies necessary for successful collaboration.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

22) Which conflict-related communication style involves attempting to satisfy the concerns of others while neglecting the self?
A) Compromising
B) Accommodating
C) Avoiding
D) Competing
Answer: B
Explanation: A) Compromising is an approach where both parties are partially satisfied; and avoiding is refusing to address a conflict.
B) Accommodating involves attempting to satisfy the concerns of others while neglecting the self.
C) Avoiding is refusing to address a conflict.
D) Competing is an assertive, power-oriented approach where one focuses on the self.
Page Ref: 2562
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.7. Discuss effective strategies for communicating and resolving conflict. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Resolve conflicts. | Nursing Process: Assessment
Learning Outcome: 37.5. Analyze aspects of conflict prevention and management.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

23) Which action is an example of covert conflict?
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A) Complaining to a friend about an assigned job task
B) Yelling at a coworker who has insulted another coworker
C) Telling a manager that you think they are being unnecessarily harsh
D) Warning a client that inappropriate contact and comments will not be tolerated
Answer: A
Explanation: A) In covert conflict, the conflict is not discussed openly; it may be avoided or ignored. Covert conflict is exhibited in reactive, repressive, and avoidant behaviors. Complaining to a friend about a job task is an example of a reactive behavior that would qualify as covert conflict.
B) Yelling at a coworker who has insulted another coworker is an example of overt conflict.
C) Telling a manager that they are being harsh is an example of overt conflict.
D) Warning a client that inappropriate comments and contact will not be tolerated is an example of overt conflict.
Page Ref: 2560
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.7. Discuss effective strategies for communicating and resolving conflict. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Resolve conflicts. | Nursing Process: Assessment
Learning Outcome: 37.5. Analyze aspects of conflict prevention and management.
MNL LO: Analyze the concept of collaboration and its application to nursing care.

24) Which individual would be included on an interdisciplinary healthcare team but not on an interprofessional healthcare team?
A) Nurse practitioner
B) Laboratory technologist
C) Pharmacist
D) Physical therapist
Answer: B
Explanation: A) Nurse practitioners would be part of both interprofessional and interdisciplinary teams.
B) The term interprofessional usually refers to professionals from various disciplines, whereas the term interdisciplinary is often used to denote that paraprofessionals or others (such as clients or family members) are also included. A laboratory technologist is considered a paraprofessional, so they would be part of an interdisciplinary team but not an interprofessional team.
C) Pharmacists would be part of both interprofessional and interdisciplinary teams.
D) Physical therapists would be part of both interprofessional and interdisciplinary teams.
Page Ref: 2553
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.C.2. Appreciate importance of intra- and interprofessional collaboration. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; collaborate and work cooperatively with others. | Nursing Process: Assessment
Learning Outcome: 37.1. Describe the nurse's role as a collaborative member of the healthcare team.

MNL LO: Analyze the concept of collaboration and its application to nursing care.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e **(Pearson)**
Module 38 Communication

The Concept of Communication

1) The nurse is caring for a client requiring a bowel prep for a colonoscopy. Which approach should the nurse use to facilitate the client's understanding of the procedure?
A) Use simple terms to explain the procedure, then ask the client to describe the procedure in their own words.
B) Use medical terminology when explaining the procedure to the client to ensure maximum accuracy and clarity.
C) Focus on intonation when describing the procedure to the client.
D) Speak slowly and loudly when providing client teaching about the procedure.
Answer: A
Explanation: A) Good verbal communication incorporates simplicity, brevity, and completeness. Simplicity involves the use of commonly understood words rather than medical terminology. Asking the client to repeat the information back in their own words gives the nurse a chance to evaluate whether the teaching has been successful.
B) Medical terminology should be avoided because this does not ensure the client understands the instructions.
C) While intonation can modify the feeling and impact of a message, focusing on intonation is less important than using easily understood terminology.
D) Speaking too slowly or too loudly could be interpreted by the client as patronizing or aggressive.

Page Ref: 2570
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity
Standards: QSEN Competencies: II.A.4. Recognize contributions of other individuals and groups in helping patient/family achieve health goals. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Scope of practice, roles, and responsibilities of health care team members, including overlaps. | Nursing Process: Implementation
Learning Outcome: 38.1. Differentiate the various forms of communication.
MNL LO: Analyze the concept of communication and its application to nursing care.

2) The nurse educator in a medical-surgical unit is demonstrating the use of new equipment to the rest of the nurses on the unit. After initial efforts at having the class gather closely around the models were met with discomfort and inattention, the nurse educator sets up the models in the front of the classroom. Which level of proxemics would be ideal for this situation?
A) 4 to 12 feet
B) 1 1/2 to 4 feet
C) 12 feet or more
D) Less than 1 1/2 feet
Answer: A
Explanation: A) Because the nurse is communicating with a group and all members of the group must be able to see the models clearly, a social distance of 4 to 12 feet would be appropriate. Social distance is characterized by a clear, visual perception of the whole individual, and it is expedient for communicating with several people at the same time.
B) A personal distance of 1 1/2 to 4 feet might still cause discomfort among participants and make it difficult for them to observe the models in full.
C) A public distance of 12 feet or more would make it hard for participants to observe the models' smaller features and would also make the communication process less personal for all parties involved.
D) An intimate distance of 1 1/2 feet or less would likely make the group members extremely uncomfortable and prevent them from seeing all aspects of the demonstration.
Page Ref: 2578
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.9. Discuss principles of effective communication. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Implementation
Learning Outcome: 38.3. Analyze the factors that influence the communication process.
MNL LO: Analyze the concept of communication and its application to nursing care.

3) The nurse is admitting a client to an inpatient psychiatric unit. The client is speaking wildly and is obviously very agitated. Which action by the nurse would be appropriate to calm the client?
A) Placing the client in a private room, away from others
B) Speaking to the client in a soft, calm tone
C) Administering a prn medication to sedate the client
D) Using short sentences when talking to the client
Answer: B
Explanation: A) Isolating the client may be necessary if the client's behavior escalates to violence, but that is not evident here and is not the first choice of action.
B) Speaking in a soft, calm manner is the first step in attempting to soothe an excited client. The nurse's tone may calm the excited client.
C) Giving a sedative is the last resort and is used only if the client is threatening to hurt self or others.
D) Using short sentences is a useful approach, but in the case of an excited client, the nurse would attempt to calm the client first.
Page Ref: 2570
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.9. Discuss principles of effective communication. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Implementation
Learning Outcome: 38.8. Analyze the nursing process as it relates to a client with impaired verbal communication.
MNL LO: Analyze the concept of communication and its application to nursing care.

4) The nurse is starting preoperative teaching when the client receives a phone call. When the call ends and the nurse resumes teaching, the client is visibly upset and begins to cry. Which therapeutic initial response by the nurse is appropriate?
A) "You can deal with whatever is upsetting you once we have finished."
B) "It's very important to focus on this teaching so that you will recover quickly after surgery."
C) "I can see that phone call has upset you. Let's talk about why you are upset before we move on with teaching."
D) "What can you do to solve the problem?"
Answer: C
Explanation: A) Because the nurse is unaware of the issue and is not knowledgeable of the client's situation, it is false reassurance to tell the client that the matter can be handled after the teaching is completed. This response also belittles the client's independence and self-efficacy, as does recommending problem solving.
B) Telling the client to focus will not relieve the anxiety of the imminent issue.
C) When clients are anxious and upset, they have difficulty focusing, especially on new information, and their anxiety becomes a barrier to effective communication. The nurse needs to prioritize the client's presenting need to express concerns and then engage in teaching at a later time, when the client is able to comprehend.
D) Asking what the client can do to solve the problem is confrontational and nontherapeutic.
Page Ref: 2570
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.B.13. Assess own level of communication skill in encounters with patients and families. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Implementation

Learning Outcome: 38.4. Analyze barriers to effective communication.
MNL LO: Analyze the concept of communication and its application to nursing care.

5) A female nurse is caring for a 21-year-old male client with a questionable gastrointestinal blockage. The healthcare provider prescribes an enema. Which reaction by the client would the nurse anticipate when planning care?

A) "May I have a visitor in the room with me for support during the procedure?"

B) "I would rather have my doctor perform this procedure."

C) "I don't know what an enema is."

D) "I am afraid of having an enema."

Answer: B

Explanation: A) The nurse would not expect the client to request the presence of another individual in the room for this procedure.

B) The nurse would anticipate that most young adult clients will be embarrassed by this procedure when the nurse and client are of different genders. When the client states that he would rather have his doctor perform the enema, he is probably motivated by embarrassment and acting on the assumption that the doctor is male.

C) Most clients in this age group would also be familiar with what an enema is, even if they have not had an enema themselves.

D) Most clients would only experience annoyance, not fear, in relation to this procedure.

Page Ref: 2571, 2577, 2579, 2583

Cognitive Level: Evaluating

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.A.9. Discuss principles of effective communication. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Planning

Learning Outcome: 38.3. Analyze the factors that influence the communication process.

MNL LO: Analyze the concept of communication and its application to nursing care.

6) The nurse is caring for a young adult client after a cervical biopsy. The client has expressed anxiety about the results. The healthcare provider peeks into the client's room and says, "The biopsy is negative." The nurse later finds the client sobbing. Which response by the nurse is most appropriate?
A) "What did the healthcare provider tell you about the biopsy?"
B) "You seem upset. Do you want to talk to me about the test results?"
C) "Why are you crying after getting such good news?"
D) "In this case, the term ‘negative' is good!"
Answer: B
Explanation: A) Asking the client what the provider told her assumes that she is crying because of what the provider said and does not allow her to express her concern in an open-ended manner.
B) The nurse does not know specifically what the client is upset about and should ask the client an open-ended question so she can talk. The healthcare provider, in delivering important news to the client, should have taken time to sit with her and discuss the test results.
C) Asking the client why she is crying about good news does not allow the client to express concern regarding the results.
D) Saying that the test results are good in this case assumes that the client has misunderstood the results, which may be true but does not allow the client to express her concerns.
Page Ref: 2596
Cognitive Level: Evaluating
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.9. Discuss principles of effective communication. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Implementation
Learning Outcome: 38.8. Analyze the nursing process as it relates to a patient with impaired verbal communication.
MNL LO: Analyze the concept of communication and its application to nursing care.

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7) A home health nurse is precepting a new nurse during a routine wound care visit. The new nurse is assessing the client's wound and notes that it is showing signs and symptoms of infection. The client's spouse asks the new nurse how the wound looks. The new nurse responds by stating, "It looks fine," but the new nurse's face indicates a different story. When evaluating the new nurse, the preceptor should note a need to work on which aspect of communication?
A) Credibility
B) Congruence
C) Timing
D) Clarity and brevity
Answer: B
Explanation: A) Credibility is the quality of being truthful, trustworthy, and reliable. Although the nurse's words in this situation may not be completely true, they do not necessarily reflect a larger problem with credibility.
B) Congruence is adjusting one's tone of speech and facial expression to match one's spoken message. If a nurse's facial expression and words are not congruent, the client and family will often suspect that something is wrong.
C) Timing means that a message is delivered when the client and family are capable of processing it fully and correctly.
D) Clarity and brevity are characteristics involving preciseness and use of few words.
Page Ref: 2579
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.9. Discuss principles of effective communication. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Evaluation
Learning Outcome: 38.1. Differentiate the various forms of communication.
MNL LO: Analyze the concept of communication and its application to nursing care.

8) The nurse is providing care for a client who has vocal cord damage and wants to implement strategies that will promote communication with this client. Which interventions would be appropriate? **Select all that apply.**
A) Facing the client when speaking
B) Having pen and paper on hand for the client
C) Making sure that the language spoken is the client's dominant language
D) Using a picture board to facilitate communication
E) Employing an interpreter
Answer: B, D
Explanation: A) Because the client cannot communicate verbally, facing the client when talking would not address the client's inability to communicate.
B) The client who is nonverbal would respond best to pen and paper.
C) Because the client cannot communicate verbally, using the client's dominant language would not address the client's inability to communicate.
D) The client who is nonverbal would respond best to use of a picture board.
E) Because the client cannot communicate verbally, using an interpreter would not address the client's inability to communicate.
Page Ref: 2583
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.9. Discuss principles of effective communication. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Implementation

Learning Outcome: 38.8. Analyze the nursing process as it relates to a patient with impaired verbal communication.
MNL LO: Analyze the concept of communication and its application to nursing care.

9) The nurse is caring for a client who was admitted to the emergency department with abdominal pain. The client speaks very little English and requires an emergency appendectomy. The nurse has enlisted the hospital interpreter to explain the procedure and help with informed consent. When the interpreter arrives, which action by the nurse is appropriate?
A) Ask the interpreter to translate as closely as possible.
B) Ask the client's family to be included in the interpreting process and exchange of information.
C) Direct questions to the interpreter and not the client.
D) Request that the interpreter use the same dialect as the client to promote understanding.
Answer: A
Explanation: A) An interpreter is an individual who mediates spoken or signed communication between people who use different languages without adding, omitting, distorting meaning, or editorializing.
B) The nurse should also avoid asking the client's family, especially a child or spouse, to help interpret.
C) The nurse should direct all questions to the client, not the interpreter.
D) It is not the interpreter's responsibility to determine the dialect with which the client is most familiar.
Page Ref: 2586
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.9. Discuss principles of effective communication. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Implementation

Learning Outcome: 38.8. Analyze the nursing process as it relates to a patient with impaired verbal communication.
MNL LO: Analyze the concept of communication and its application to nursing care.

10) The nurse is providing care for a client who is about to be discharged. The nurse is discussing the discharge orders with the client's primary healthcare provider. Which statement by the nurse is an appropriate example of using assertive communication?
A) "Can we talk about this client prior to discharge?"
B) "That new medication you prescribed for the client is ineffective."
C) "I am worried about the client's blood pressure. It remains high even with the new medication."
D) "Excuse me, Doctor, I think you need to do something about the client's blood pressure."
Answer: C
Explanation: A) Asking whether the provider can talk about a client does not give the provider enough information.
B) Stating that the new medication is ineffective could be interpreted as an inflammatory remark by the provider.
C) The nurse who expresses concern because the client's blood pressure remains high even with new medication is being assertive, clear, and concise.
D) Saying the provider must do something about the client's blood pressure may cause the provider to become defensive.
Page Ref: 2581
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.9. Discuss principles of effective communication. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Implementation

Learning Outcome: 38.6. Summarize the attributes of a nurse who uses assertive communication.
MNL LO: Analyze the concept of communication and its application to nursing care.

11) A young adolescent client is in the hospital preparing for major surgery for the removal of a tumor on the kidney. The client's mother tells the nurse that she doesn't want her child to receive narcotics for postoperative pain. Which response should the nurse make?
A) "Okay, I'll tell the healthcare provider not to order any. Are you sure you want to do this?"
B) "The pain will be severe. Why don't we ask your child about this?"
C) "Your child's pain will be severe after the surgery. Can you tell me why you feel this way?"
D) "You do not have a choice of medication. Decisions involving pain relief are up to the healthcare providers."
Answer: C
Explanation: A) Acceding to the mother's request is submissive communication and would not be in the best interests of the child.
B) Putting the child in the middle of the discussion is a divisive maneuver.
C) As a client advocate, the nurse should defend the need for effective pain medication by using assertive communication. Thus, the best response is for the nurse to tell the mother the truth about the client's pain and then explore the mother's objection to the drugs.
D) Telling the mother she does not have a choice is aggressive and untrue.
Page Ref: 2581-2582
Cognitive Level: Evaluating
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.9. Discuss principles of effective communication. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Implementation
Learning Outcome: 38.6. Summarize the attributes of a nurse who uses assertive communication.
MNL LO: Analyze the concept of communication and its application to nursing care.

12) The nurse is caring for a client who is having difficulty understanding the dressing changes that need to be completed in the home as part of postdischarge wound care. The client asks the nurse to demonstrate the procedure again and allow the client's spouse to perform the procedure while the nurse watches. Which outcome is likely to occur as a result of the client's request?
A) A slightly increased chance that the wound will become infected due to exposure during dressing changes
B) Less compassionate care for the client due to the nurse's irritation by the request
C) A greater likelihood that the wound will heal appropriately
D) A guarantee that the spouse will change the dressings correctly
Answer: C
Explanation: A) Infection of a wound that is dressed correctly is not the likely result of this request.
B) No information is provided about the nurse's response to the request, and even if the nurse is irritated, these feelings should not affect the quality of care.
C) The client used assertive communication to ensure that the dressing changes would be performed correctly, which will likely result in appropriate healing of the client's wound.
D) There is no guarantee that the client's spouse will always perform the task correctly because humans make mistakes.
Page Ref: 2581-2582
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.B.15. Communicate care provided and needed at each transition in care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Implementation
Learning Outcome: 38.6. Summarize the attributes of a nurse who uses assertive communication.
MNL LO: Analyze the concept of communication and its application to nursing care.

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13) The nurse is caring for a client with a new colostomy. The client has been taught how to perform colostomy care and has been successful with return demonstration to the staff. Although the client is able to perform care independently and has asked to do so, the charge nurse has instructed the nursing staff to continue performing colostomy care for this client. When addressing this issue directly with the charge nurse, which statement by a staff nurse is the most appropriate?
A) "The client will change the apparatus whether you like it or not."
B) "The client has been trained to change the apparatus and has expressed interest in performing this procedure independently."
C) "You have no right to continue delegating this task to nurses when the client has been trained to change the apparatus."
D) "I am going to tell the nurse manager that you won't allow the client to change the apparatus independently."
Answer: B
Explanation: A) Insisting that the client will continue to change the apparatus will likely result in the charge nurse taking further action to prevent the client from performing self-care.
B) The nurse should make a clear, assertive statement saying that the client learned the procedure and wishes to execute it.
C) Saying "You have no right . . ." is a challenge to the charge nurse and will only result in escalation of the argument.
D) Telling the charge nurse that the nurse manager will be notified is a threat and inflames the situation.
Page Ref: 2581-2582
Cognitive Level: Evaluating
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.9. Discuss principles of effective communication. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Implementation
Learning Outcome: 38.6. Summarize the attributes of a nurse who uses assertive communication.
MNL LO: Analyze the concept of communication and its application to nursing care.

14) Which barrier to communication involves asking a client for information chiefly out of curiosity rather than with the intent to assist the client?
A) Challenging
B) Probing
C) Testing
D) Rejecting
Answer: B
Explanation: A) Challenging refers to giving a response that makes clients prove their statement or point of view.
B) Probing involves asking a client for information chiefly out of curiosity rather than out of a desire to assist the client. Probing often places clients in a defensive position and violates their privacy.
C) Testing involves asking questions that make a client admit to something.
D) Rejecting is refusing to discuss certain topics with a client.
Page Ref: 2580
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.9. Discuss principles of effective communication. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Assessment
Learning Outcome: 38.4. Analyze barriers to effective communication.
MNL LO: Analyze the concept of communication and its application to nursing care.

15) Which statement made by the nurse is an example of the communication barrier known as testing?
A) "Most people have little to no pain after this type of procedure."
B) "Tell me when and why you started smoking marijuana."
C) "Do you think you're the only client on the unit right now?"
D) "How are you still in pain after receiving both doses of medication?"
Answer: C
Explanation: A) Telling the client that most people have little or no pain after a procedure is an example of stereotyping.
B) Asking about why a client started using marijuana may be an example of probing.
C) Testing involves asking questions that make the patient admit to something. These responses permit the patient only limited answers and often meet the nurse's need rather than the patient's. Of the options listed here, "Do you think you're the only client on the unit right now?" best meets this definition.
D) Questioning how the client is still in pain after medication administration is an example of challenging, or making clients prove their statements or point of view.
Page Ref: 2580
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.9. Discuss principles of effective communication. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Implementation
Learning Outcome: 38.4. Analyze barriers to effective communication.
MNL LO: Analyze the concept of communication and its application to nursing care.

Exemplar 38.A Groups and Group Communication

1) A nurse case manager spends the morning in a peer discussion and the afternoon in an ad hoc quality management committee meeting that is led by the hospital administrator. Which two types of groups has the nurse case manager participated in?
A) Camaraderie group and information group
B) Work group and administrative group
C) Primary group and secondary group
D) Support group and governance group
Answer: C
Explanation: A) Camaraderie and information are functions of groups.
B) Work and administrative are functions of groups.
C) Primary groups are typically informal groups that communicate regularly in face-to-face interactions. The case manager's peer group would be considered a primary group. Secondary groups are larger, more impersonal, and goal-oriented. The quality management committee would be classified as a secondary group.
D) Support and governance are functions of groups.
Page Ref: 2588
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.4. Recognize contributions of other individuals and groups in helping patient/family achieve health goals. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; collaborate and work cooperatively with others; resolve conflicts; respond to moral and ethical challenges. | Nursing Process: Implementation
Learning Outcome: 38.A. Analyze groups and group communication. Describe the types, functions, levels of formality, and characteristics of effective groups.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

2) Which term encompasses the way a group functions, communicates, sets goals, and achieves objectives?
A) Cohesiveness
B) Group dynamics
C) Commitment
D) Member behavior
Answer: B
Explanation: A) Cohesiveness is an aspect of group dynamics.
B) Group dynamics, or group processes, are related to how a group functions, communicates, sets goals, and achieves objectives.
C) Commitment is an aspect of group dynamics.
D) Member behavior is an aspect of group dynamics.
Page Ref: 2588
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.4. Recognize contributions of other individuals and groups in helping patient/family achieve health goals. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Teamwork: Contributions of other individuals and groups in helping patient/family achieve health goals. | Nursing Process: Assessment
Learning Outcome: 38.A. Analyze groups and group communication. Outline the aspects of group dynamics.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

3) The nurse is developing objectives for a charter group of nurses from a national association. Which characteristics should the nurse expect to encounter when working with this semiformal group?
A) The group has a formal structure, with voluntary, selective membership and structured activities during meeting times.
B) The group has a formal structure, with structured activities, leadership selection from above, and easily recognized basic objectives.
C) The group has an informal structure, with voluntary, selective membership and negotiable day-to-day operating standards.
D) The group has an informal structure, with superimposed rules and managers who are symbols of authority.
Answer: A
Explanation: A) There are three levels of group formality: formal, semiformal, and informal. Most groups move in and out of all three levels, but traditionally, a charter group of an association is a semiformal group with a formal structure, carefully delineated hierarchy, and selective, voluntary membership with attached prestige and status.
B) Semiformal groups have structured deliberate activities during meetings.
C) Semiformal groups have structured deliberate activities during meetings, objectives and goals that are not easily changed, negotiable day-to-day operating standards and methods, and a leader who has direct control over the choice of a successor.
D) Semiformal groups also have structured deliberate activities during meetings, objectives and goals that are not easily changed, negotiable day-to-day operating standards and methods, and a leader who has direct control over the choice of a successor.
Page Ref: 2589

Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.4. Recognize contributions of other individuals and groups in helping patient/family achieve health goals. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Teamwork: Contributions of other individuals and groups in helping patient/family achieve health goals. | Nursing Process: Planning
Learning Outcome: 38.A. Analyze groups and group communication. Describe the types, functions, levels of formality, and characteristics of effective groups.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

4) The nurse is sitting in on a meeting for clients on a behavioral health unit. Which characteristics indicate that the group is functioning effectively? **Select all that apply.**
A) The expertise of group members is being used.
B) The group atmosphere is positive.
C) Members feel satisfied with their participation.
D) The group listens to the ideas of certain group members.
E) The discussion focuses on all issues brought by group members.
Answer: A, B, C
Explanation: A) Groups function most effectively when they use group members' expertise.
B) Groups function most effectively when there is a positive atmosphere.
C) In an effective group, members feel satisfied with their participation.
D) Groups function most effectively when they listen to the ideas of all members.
E) In an effective group, discussion focuses on the major decisions to be made, and members feel committed to these decisions and responsible for their implementation.
Page Ref: 2590
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.4. Recognize contributions of other individuals and groups in helping patient/family achieve health goals. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Teamwork: Contributions of other individuals and groups in helping patient/family achieve health goals. | Nursing Process: Assessment
Learning Outcome: 38.A. Analyze groups and group communication. Describe the types, functions, levels of formality, and characteristics of effective groups.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

5) The nurse is providing teaching for an inpatient support group meeting. Which group behavior indicates that the teaching was effective?

A) The group members appear relaxed and interested in the topic.
B) The group members are tentative in expressing their feelings.
C) The group avoids discussion about their signs and symptoms.
D) The group members appear self-conscious when asked questions about their condition.

Answer: A

Explanation: A) To be effective, a group must accomplish its goals, maintain cohesion, and develop/modify its structure to improve effectiveness.
B) The features of an effective group include leader and member participation.
C) The features of an effective group include open, two-way communication.
D) The features of an effective group include cohesion; conflict tolerance; and shared power.

Page Ref: 2590
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.4. Recognize contributions of other individuals and groups in helping patient/family achieve health goals. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Teamwork: Contributions of other individuals and groups in helping patient/family achieve health goals. | Nursing Process: Assessment
Learning Outcome: 38.A. Analyze groups and group communication. Describe the types, functions, levels of formality, and characteristics of effective groups.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

6) Four groups of nurses are attempting to determine which methods are most effective for teaching patients about proper self-care. Which of these groups is least likely to arrive at a successful decision in a timely manner?
A) The group that launches a pilot project to determine which teaching methods are most effective
B) The group that uses scenario planning to evaluate the potential results of various teaching methods
C) The group that uses trial and error to gauge the effectiveness of various teaching methods
D) The group that uses a decision tree to visualize the potential results of various teaching methods
Answer: C
Explanation: A) Use of pilot projects are more likely to result in successful decision making because this method involves proposal and analysis of various alternatives prior to taking action.
B) Scenario planning is more likely to result in successful decision making.
C) Trial-and-error techniques are the most haphazard method for decision making. Managers and groups who use these techniques are typically seen as poor problem solvers, especially in a healthcare context.
D) A decision tree is more likely to result in successful decision making.
Page Ref: 2590
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.4. Recognize contributions of other individuals and groups in helping patient/family achieve health goals. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Teamwork: Contributions of other individuals and groups in helping patient/family achieve health goals. | Nursing Process: Assessment

Learning Outcome: 38.A. Analyze groups and group communication. Outline the aspects of group dynamics.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

7) Which situation is an example of countertransference in the group setting?
A) After failing at an assigned task, the members of a group place all blame for this failure on a single group member.
B) A group member reveres the group's leader, largely because the leader possesses many similarities to the member's mother, whom he adores.
C) The members of a group become so caught up in the group's current beliefs and actions that they fail to recognize simple changes that would greatly improve the group's efficiency.
D) The leader of a group distrusts one of the group members solely because the member reminds him of his ex-wife.
Answer: D
Explanation: A) The scenario in which the members of a group place all blame on one person is an example of scapegoating.
B) The scenario in which a group member reveres the leader because she reminds him of his mother is an example of transference.
C) The scenario in which the group members become excessively caught up in group processes is an example of groupthink.
D) Countertransference occurs when leaders respond to group members because of reactions from earlier relationships. The leader who distrusts the group member because of similarities to his ex-wife is exhibiting countertransference.
Page Ref: 2591-2592
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.4. Recognize contributions of other individuals and groups in helping patient/family achieve health goals. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Teamwork: Contributions of other individuals and groups in helping patient/family achieve health goals. | Nursing Process: Assessment

Learning Outcome: 38.A. Analyze groups and group communication. List group problems that nurses should recognize and avoid.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

8) Which statements are true with regard to monopolizing in the group setting? **Select all that apply.**
A) Group members who engage in monopolizing behavior do so intentionally.
B) When one member of a group engages in monopolizing behavior, the other group members may become angry or frustrated.
C) Monopolizing behavior may be motivated by anxiety or a need for attention, recognition, and approval.
D) One useful strategy for dealing with monopolizing is to simply and directly interrupt the individual who is engaging in this behavior.
E) It occurs when members of a group fail to disagree or criticize the majority members.
Answer: B, C, D
Explanation: A) Many compulsive talkers are unaware of their behavior and its effect on others.
B) Monopolizing is the domination of a discussion by one member of a group. When this behavior occurs, a sense of resentment may develop within the group, and some members may direct their frustration and anger toward the group leader, whom they expect to do something to stop the monopolizer's behavior.
C) Monopolizing behavior may be motivated by anxiety or a need for attention, recognition, and approval.
D) One useful strategy for dealing with monopolizing is to interrupt the monopolizer simply, directly, and supportively.
E) Group think is a type of decision making characterized by members of a group failing to disagree or criticize the majority members.
Page Ref: 2591
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.4. Recognize contributions of other individuals and groups in helping patient/family achieve health goals. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Teamwork: Contributions of other individuals and groups in helping patient/family achieve health goals. | Nursing Process: Assessment
Learning Outcome: 38.A. Analyze groups and group communication. List group problems that nurses should recognize and avoid.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

Exemplar 38.B Therapeutic Communication

1) The nurse is caring for an older adult client in a long-term care facility. Which behavior by the nurse conveys physical attending when communicating with this client?
A) Facilitating and taking action when needed
B) Maintaining a proper social distance when speaking with the client
C) Leaning toward the client during conversation
D) Being concrete about actions that need to be taken during client care
Answer: C
Explanation: A) Facilitating and taking action does not convey physical attending.
B) Maintaining social distance does not convey physical attending.
C) The nurse best conveys physical attending by leaning toward the client, which communicates involvement.
D) Being concrete is a method of communicating information to the client, not a method of conveying physical attending.
Page Ref: 2595
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.6. Describe impact of own communication style on others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Effective strategies for communicating with different members of the health team, including patients and families. | Nursing Process: Implementation
Learning Outcome: 38.B. Analyze the interactive process of therapeutic communication. Summarize the various techniques used by nurses to support patients.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

2) A nurse educator is teaching a group of students about the use of touch. In which situation is it appropriate to use touch as a means of communication?
A) A client's family member is making inappropriate comments to the nurse
B) An upset spouse is alone, and the client has just expired
C) Speaking to a client with a history of physical abuse
D) A young male client asks a young student nurse for a hug
Answer: B
Explanation: A) Touch is not appropriate when a client's family member is making inappropriate comments to the nurse.
B) Touch is appropriate in the situation involving the grieving spouse.
C) Clients with a history of physical or sexual abuse and/or certain mental illnesses may misinterpret the use of touch.
D) Touch is not appropriate when a client asks a student nurse for a hug.
Page Ref: 2595
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.6. Describe impact of own communication style on others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Effective strategies for communicating with different members of the health team, including patients and families. | Nursing Process: Implementation
Learning Outcome: 38.B. Analyze the interactive process of therapeutic communication. Summarize the various techniques used by nurses to support patients.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

3) The nurse completes a teaching session on wound care for a client who will require dressing changes after discharge. The nurse then evaluates the effectiveness of the teaching session and determines that more education is required. Which statement by the nurse is appropriate in this situation?

A) "Let me clarify again some of the steps that are required during wound care."
B) "You didn't pay attention, did you?"
C) "Here, let me do it for you."
D) "I don't think you understood me correctly the first time."

Answer: A

Explanation: A) Responding with some clarifications indicates that the client understood some of the teaching and preserves the client's dignity and trust in the nurse.

B) Beginning a negative phrase with "you" is assigning blame, which impedes the therapeutic relationship.

C) Telling the client that the nurse can take care of the task defeats the goal of feedback; the nurse would want to instill self-confidence in the client, and this type of action will hurt that goal.

D) Saying that the client did not understand the information is belittling.

Page Ref: 2596
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.6. Describe impact of own communication style on others. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Teamwork: Effective strategies for communicating with different members of the health team, including patients and families. | Nursing Process: Evaluation

Learning Outcome: 38.B. Analyze the interactive process of therapeutic communication. Summarize the various techniques used by nurses to support patients.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

4) A client with cancer is struggling with chronic pain. The nurse tells the client, "It is normal to feel frustrated about the discomfort." Which skill associated with the working phase of the nurse-client relationship does the nurse's statement best reflect?
A) Confronting
B) Respect
C) Concreteness
D) Genuineness
Answer: B
Explanation: A) Confronting points out discrepancies between thoughts, feelings, and actions that inhibit the client's self-understanding or exploration of specific areas.
B) Respect is correct because the nurse is validating the client's feelings.
C) Concreteness involves assisting the client by giving specific examples rather than speaking in generalities.
D) This situation is not an example of genuineness because the nurse is giving information versus making a personal statement.
Page Ref: 2604
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.11. Recognize the boundaries of therapeutic relationships. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Adapt communication to the team and situation to share information or solicit input; initiate requests for help when appropriate. | Nursing Process: Implementation
Learning Outcome: 38.B. Analyze the interactive process of therapeutic communication. Outline the phases of the therapeutic relationship.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

5) The nurse is establishing a therapeutic relationship with a new client. Which statement by the nurse best exemplifies empathy?
A) "I wouldn't be afraid if I were you."
B) "You shouldn't have done it that way."
C) "You seem to be frightened by the procedure. Tell me how you are feeling."
D) "I know just how you feel, because my mother has the same illness."
Answer: C
Explanation: A) Telling the client not to be afraid is demeaning.
B) Saying the client should not have done something is passing judgment and inappropriate.
C) To be able to empathize with clients, the nurse must be able to understand and acknowledge the ideas that the client is expressing or that the client feels are important to the situation. By stating that the client seems frightened and asking the client to describe their feelings, the nurse is demonstrating empathy.
D) The nurse should not say they know how the client feels; such a statement will likely be met with disbelief, because one individual never knows how another individual is feeling unless that individual tells them.
Page Ref: 2594
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.6. Describe impact of own communication style on others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Adapt communication to the team and situation to share information or solicit input; initiate requests for help when appropriate. | Nursing Process: Implementation

Learning Outcome: 38.B. Analyze the interactive process of therapeutic communication. Summarize the various techniques used by nurses to support patients.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

6) The nurse is caring for a school-age client who is scheduled to have major heart surgery the next morning. The nurse enters the room to administer a medication and finds the client crying. Which response by the nurse is most therapeutic?

A) "Would you like some toys from the playroom?"
B) "I'm going to go get the doctor."
C) "You shouldn't cry. You are not in pain."
D) "It is okay to cry. I know this is scary."

Answer: D

Explanation: A) Distraction is not appropriate when the client is clearly upset, so the nurse should not ask whether the client wants toys.

B) Leaving to get the doctor could be seen by the child as abandonment and would signal that the nurse is uncomfortable with the child.

C) Telling the client not to cry invalidates the client's feelings.

D) Assertive communication is appropriate in the group setting, but for this client, the nurse should be accepting of the client's feelings of fear.

Page Ref: 2605

Cognitive Level: Evaluating

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: II.A.6. Describe impact of own communication style on others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Communicate information effectively; listen openly and cooperatively. | Nursing Process: Implementation

Learning Outcome: 38.B. Analyze the interactive process of therapeutic communication. Differentiate considerations related to therapeutic communication throughout the lifespan.

MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

7) The nurse is providing care for a client who is newly diagnosed with chronic obstructive pulmonary disease (COPD). Which action indicates that the nurse is using therapeutic communication?
A) Asks appropriate questions about the client's medical history.
B) Closes the conversation with an anecdote about breathing.
C) Plans to tell the client about a COPD support group.
D) Bonds with the client by describing her own experiences living with COPD.
Answer: A
Explanation: A) Attentive or "mindful" listening is a therapeutic communication technique that involves listening and absorbing the content and feeling of what an individual is conveying, without selectivity. This technique requires paying attention to the client's total message, both verbal and nonverbal, and noting whether these communications are congruent. During attentive listening, the nurse focuses not on the nurse's own needs but rather on the client's needs. By asking appropriate questions about the client's medical history and carefully noting the client's responses, the nurse is engaging in attentive listening and thus in therapeutic communication.
B) An anecdote about breathing is not therapeutic communication.
C) Planning to share information about a support group is not therapeutic communication.
D) Sharing personal information is not therapeutic communication.
Page Ref: 2594
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.6. Describe impact of own communication style on others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Effective strategies for communicating with different members of the health team, including patients and families. | Nursing Process: Implementation
Learning Outcome: 38.B. Analyze the interactive process of therapeutic communication. Summarize the various techniques used by nurses to support patients.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

8) The nurse is providing care to a client who is newly diagnosed with human immunodeficiency virus (HIV). Which statements by the nurse could inhibit the development of therapeutic communication with this client? **Select all that apply.**
A) "I am so happy today! I just found out that I got accepted into nurse practitioner school!"
B) "Well, I guess your lifestyle finally caught up to you."
C) "One of my cousins has AIDS. It is hard to watch him die."
D) "Tell me your feelings about the diagnosis."
E) "Would you like to talk about the new medications you've been prescribed?"
Answer: A, B, C
Explanation: A) Various obstacles to attentive listening can inhibit the development of therapeutic communication. Being concerned with oneself is an obstacle to active listening.
B) Assuming to know the client's lifestyle is an obstacle to active listening.
C) Identifying is an obstacle to active listening.
D) Using open-ended questions enhances therapeutic communication.
E) Providing general leads-in enhances therapeutic communication.
Page Ref: 2585
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.6. Describe impact of own communication style on others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Effective strategies for communicating with different members of the health team, including patients and families. | Nursing Process: Implementation
Learning Outcome: 38.B. Analyze the interactive process of therapeutic communication. Summarize the various techniques used by nurses to support patients.

MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

9) The nurse is providing care to a client who is diagnosed with hypertension. Which response by the nurse is an appropriate example of informational confrontation with the client?
A) "I noticed you rubbing your head and your eyes. Are you hurting? Let's take your blood pressure."
B) "I heard raised voices when I was coming down the hall to your room. Are you upset?"
C) "It is 3 p.m. and time to take your blood pressure before I give you your medication."
D) "Is the blood pressure medication making your head hurt?"
Answer: A
Explanation: A) An informational confrontation describes the visible behavior of another individual. "I noticed you rubbing your head and your eyes" is an example of an informational confrontation.
B) Asking if the client is upset because of hearing raised voices is an interpretive confirmation statement.
C) Stating time to take blood pressure before medications does not describe the behavior of the client.
D) Asking if medication is causing the client a side effect is an example of interpretive confirmation.
Page Ref: 2601
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.6. Describe impact of own communication style on others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Effective strategies for communicating with different members of the health team, including patients and families. | Nursing Process: Implementation

Learning Outcome: 38.B. Analyze the interactive process of therapeutic communication. Summarize the various techniques used by nurses to support patients.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

10) Which phase is completed first in the therapeutic nurse-client relationship?
A) Introductory phase
B) Working phase
C) Preinteraction phase
D) Anticipatory phase
Answer: C
Explanation: A) The introductory phase, also called the orientation or pretherapeutic phase, sets the tone for the nurse-client relationship.
B) The working or middle phase of the nurse-client relationship has the stages of identification and exploitation,
C) During the preinteraction phase, the nurse plans for the initial face-to-face meeting with the client.
D) Anticipatory is not a phase of the nurse-client relationship.
Page Ref: 2603
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.11. Recognize the boundaries of therapeutic relationships. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship-Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Implementation
Learning Outcome: 38.B. Analyze the interactive process of therapeutic communication. Outline the phases of the therapeutic relationship.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

11) Which statement by the nurse demonstrates the therapeutic communication technique of offering self?
A) "Would you like to talk with me about your emotions right now?"
B) "I'm not sure I understand. Please tell me more about the situation."
C) "I don't know the answer to your question, but I will check with the physician."
D) "I'll stay here with you until your family arrives."
Answer: D
Explanation: A) Asking whether the client wants to talk about their emotions is an example of providing general leads.
B) Asking the client to provide more details about a situation is an example of using open-ended questions.
C) Offering to get answers from the physician is an example of giving information.
D) Offering self involves suggesting one's presence, interest, or wish to understand the client without making any demands or attaching conditions that the client must comply with to receive the nurse's attention. The nurse's offer to stay with the client until the family arrives is an example of offering self.
Page Ref: 2596
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.6. Describe impact of own communication style on others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Effective strategies for communicating with different members of the health team, including patients and families. | Nursing Process: Implementation
Learning Outcome: 38.B. Analyze the interactive process of therapeutic communication. Summarize the various techniques used by nurses to support patients.
MNL LO: Demonstrate understanding of the concept of communication when providing group communication and therapeutic communication.

WwW.TeSm.Ws

Exemplar 38.C Documentation

1) The nurse hired to be the medical information system (MIS) trainer assesses the security of clients' electronic medical records. According to HIPAA's Security Rule, which recommendations by the nurse will enhance security? **Select all that apply.**
A) Assign each staff member a unique username and password.
B) Install a firewall.
C) Store computer-generated worksheets in a locked vault.
D) Turn monitors away from view when unattended.
E) Assign each unit unique passwords.
Answer: A, B
Explanation: A) To comply with HIPAA's Security Rule, institutions should assign individual passwords to each staff member for logging on and off computer files.
B) Firewalls should be installed to enhance the security of client records.
C) Computer-generated worksheets should be shredded when no longer needed.
D) Client information should not be displayed on unattended terminals, regardless of which direction the monitor faces.
E) A password is not assigned to a unit.
Page Ref: 2608
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.3. Protect confidentiality of protected health information in electronic health records. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Implementation
Learning Outcome: 38.C. Analyze documentation as it relates to communication. Outline the legal and ethical considerations of documentation.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

2) The nurse is conducting a health history on a client who is being admitted to a medical-surgical unit for the treatment of chronic pain. The client is concerned about privacy and asks why it is necessary for the nurse to ask for private information and then document it in the medical record. Which response by the nurse is most appropriate?
A) "You will be able to read the record and review your care."
B) "Documentation decreases the likelihood that you will have to repeat this information to others who will care for you."
C) "Your family can review the record and ensure that your care is appropriate."
D) "A record ensures there are no breaches of confidentiality."
Answer: B
Explanation: A) The client can read the record, but that is not a reason to keep one.
B) A client's record serves as a vehicle by which different health professionals who interact with the client communicate with one another. This prevents fragmentation, repetition, and delays in client care, and it relieves the client from having to repeat information to each provider offering care.
C) The client's family does not have access to the record.
D) Recordkeeping does not prevent breaches of confidentiality.
Page Ref: 2608
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.3. Protect confidentiality of protected health information in electronic health records. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Implementation
Learning Outcome: 38.C. Analyze documentation as it relates to communication. Summarize the purposes of patient records.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

3) The nurse is caring for a client who received analgesic medication via central line to treat pain associated with cancer. After reassessing the client's response, which section of the PIE record will the nurse use when documenting the client's care?
A) Evaluation
B) Progress notes
C) Problem
D) Intervention
Answer: A
Explanation: A) Reassessing the client's pain level after medication administration is considered evaluation and would be documented under "E."
B) Progress notes are not part of the identified labels of PIE charting.
C) The problem statement would be labeled "P."
D) Interventions such as medication administration would be labeled "I."
Page Ref: 2610
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.B.4. Document and plan patient care in an electronic health record. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Carefully maintain and use electronic and/or written health records. | Nursing Process: Implementation
Learning Outcome: 38.C. Analyze documentation as it relates to communication. Outline various types of documentation systems.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

4) Use of flow sheets would be most appropriate during which phase of the nursing process?

A) Evaluation

B) Diagnosis

C) Implementation

D) Planning

Answer: C

Explanation: A) Flow sheets are not used to evaluate care.

B) Flow sheets are not used to identify nursing problems.

C) Flow sheets use specific assessment criteria in a particular format. They are frequently used on a client's chart to record routine nursing tasks and assessment data. Examples of flow sheets include a graphic record, fluid balance record, daily nursing assessments record, patient teaching record, patient discharge record, and skin assessment record. Typically, flow sheets are used during the assessment and implementation portions of the nursing process.

D) Flow sheets are not used to plan care.

Page Ref: 2613

Cognitive Level: Understanding

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: VI.B.4. Document and plan patient care in an electronic health record. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Carefully maintain and use electronic and/or written health records. | Nursing Process: Implementation

Learning Outcome: 38.C. Analyze documentation as it relates to communication. Summarize the documentation of nursing activities.

MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

5) The nurse manager is educating staff nurses about the types and frequency of documentation required for clients being cared for in long-term care facilities. These requirements originate from which laws and regulatory bodies? **Select all that apply.**
A) Problem-Oriented Medical Record (POMR) Act
B) Omnibus Budget Reconciliation Act (OBRA)
C) Health Care Financing Administration (HCFA)
D) Minimum Data Set (MDS) Act
E) American Recovery and Reinvestment Act (ARRA)
Answer: B, C, E
Explanation: A) The POMR is a system of medical recordkeeping, not a law or regulatory body.
B) Long-term care facilities must comply with documentation requirements set forth in the Omnibus Budget Reconciliation Act (OBRA) of 1987.
C) Long-term care facilities must comply with regulations established by the Health Care Financing Administration (HCFA).
D) The Minimum Data Set (MDS) is an effort to establish standards for collecting standardized, essential nursing data for inclusion in computer databases. Although established under OBRA, the MDS is not a specific law or regulatory body.
E) Long-term care facilities must comply with documentation requirements set forth in the American Recovery and Reinvestment Act (ARRA) of 2009.
Page Ref: 2609, 2613
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.B.4. Document and plan patient care in an electronic health record. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Carefully maintain and use electronic and/or written health records. | Nursing Process: Implementation
Learning Outcome: 38.C. Analyze documentation as it relates to communication. Outline the legal and ethical considerations of documentation.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

6) When documenting in a client's medical record, the nurse writes a narrative note regarding abnormal assessment findings. Based on this information, which type of charting is the nurse using?
A) Computerized documentation
B) Charting by exception (CBE)
C) SOAP charting
D) Focus charting
Answer: B
Explanation: A) Computerized documentation is a way to manage the volume of information required in a client's chart, and different systems may include a variety of setups and programs.
B) Charting by exception (CBE) is a documentation system in which only abnormal or significant findings or exceptions to norms are recorded. Flow sheets, standards of nursing care, and bedside access to chart forms are all incorporated into CBE.
C) SOAP charting is a way to organize data and information in the client's record: S indicates subjective data, O indicates objective data, A indicates assessment, and P indicates plan of care.
D) Focus charting is organized into data, action, and response sections, referred to as DAR.
Page Ref: 2610
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.B.4. Document and plan patient care in an electronic health record. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Carefully maintain and use electronic and/or written health records. | Nursing Process: Implementation
Learning Outcome: 38.C. Analyze documentation as it relates to communication. Outline various types of documentation systems.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

7) The healthcare provider prescribes a verbal order of digoxin for a client who will be discharged in the morning. When documenting the order in the medical record, which action by the nurse is most appropriate?
A) Entering "digoxin, .0125 mg QD"
B) Entering "digoxin, 0.0125 mg QD PO"
C) Entering "digoxin, 0.0125 mg, once daily by mouth"
D) Entering "digoxin, 1 pill each day"
Answer: C
Explanation: A) The nurse should write out "once daily" instead of using the abbreviation "QD," which may be interpreted incorrectly.
B) Writing "by mouth" is preferable to using the abbreviation "PO."
C) Although many healthcare facilities supply an approved list of abbreviations and symbols, the nurse can best prevent confusion by writing out the order in full. This means the nurse should place a zero before the decimal when recording the dosage, write out once daily, and write out by mouth.
D) Simply recording "1 pill each day" is not appropriate because it does not specify a dosage amount.
Page Ref: 2614-2615
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.B.4. Document and plan patient care in an electronic health record. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Carefully maintain and use electronic and/or written health records. | Nursing Process: Implementation

Learning Outcome: 38.C. Analyze documentation as it relates to communication. Outline general guidelines for recording documentation.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

8) The nurse educator is teaching a group of nursing students about the purposes of documentation and medical records. Which purpose should the nurse exclude in the teaching session with the students?
A) Communication
B) Planning
C) Employee discipline
D) Research
Answer: C
Explanation: A) Client records are kept for a number of purposes. These include communication among healthcare professionals who are treating the same client.
B) Client records are kept for a number of purposes. These include planning client care to evaluate care plan effectiveness.
C) Although recordkeeping provides necessary legal evidence of the care provided and can thus be referenced during the employee discipline process, employee discipline is not a primary purpose of the medical record.
D) Client records are kept for a number of purposes. These include research to help all clients.
Page Ref: 2608
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.2. Value technologies that support clinical decision-making, error prevention, and care coordination. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Quality and Safety: Carefully maintain and use electronic and/or written health records. | Nursing Process: Planning
Learning Outcome: 38.C. Analyze documentation as it relates to communication. Summarize the purposes of patient records.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

9) The nurse is assigned to provide care to a client with chronic obstructive pulmonary disease (COPD). Overnight, the client's oxygen saturation levels decreased, and the client has been placed on oxygen by the respiratory therapist. In which area would the nurse document the change in the client's condition when using focus charting?
A) Data
B) Action
C) Problem
D) Response
Answer: A
Explanation: A) In focus charting, a change in the client's condition would be documented under data.
B) In focus charting, the action would be contacting the respiratory therapist to provide oxygen for the client.
C) Problem is not a specific category when using focused charting.
D) In focus charting, the response would be the outcome after the client is provided with oxygen.
Page Ref: 2610
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.B.4. Document and plan patient care in an electronic health record. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Carefully maintain and use electronic and/or written health records. | Nursing Process: Implementation
Learning Outcome: 38.C. Analyze documentation as it relates to communication. Outline various types of documentation systems.

MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

Exemplar 38.D Reporting

1) A novice nurse asks the preceptor why the staff spends time talking about clients between shifts when the oncoming nurses can read the clients' charts instead. Which response should the preceptor make?
A) "Maybe we should suggest primary nursing as an alternative."
B) "Change-of-shift reporting ensures that oncoming staff know the most critical information about the clients they'll be caring for."
C) "Shift changes have always been done this way."
D) "You're right. Talking about clients during shift changes is a waste of time."
Answer: B
Explanation: A) Primary nursing promotes continuity of care, but even the primary nurse would need to be informed of client changes that occurred during his or her absence.
B) Nurses often do not have time to read clients' charts prior to assuming care, which could result in errors and assumptions. By participating in change-of-shift reports, outgoing nurses can ensure that oncoming staff are aware of critical information.
C) Stating that shift changes have always been done a certain way does not help the novice nurse understand why a change-of-shift report is necessary.
D) The preceptor should not tell the new nurse that change-of-shift reports are a waste of time because these reports allow for communication of valuable client data.
Page Ref: 2617
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.15. Communicate care provided and needed at each transition in care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Communicate effectively with different individuals (team members, other care providers, patients, families, etc.) so as to minimize risks associated with handoffs among providers and across transitions in care. | Nursing Process: Implementation
Learning Outcome: 38.D. Analyze reporting as it relates to communication. Describe the handoff report.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

2) The nurse is caring for a client who is reporting a pain level of 8 on a 0-to-10 numeric pain scale. The nurse administers the prescribed pain medication. When the nurse re-evaluates the client 1 hour later, the client is still reporting a pain level of 8. Which action by the nurse is appropriate at this time?
A) Wait for the healthcare provider to make rounds to report the problem.
B) Report to the healthcare provider by telephone.
C) Increase the dosage of the medication.
D) Include an entry in the nursing report indicating that the medication is ineffective.
Answer: B
Explanation: A) Waiting for the provider to arrive could cause the client to experience a great deal of pain in the interim.
B) In this case, reporting to the healthcare provider by telephone is appropriate.
C) The nurse cannot alter the dose of medication.
D) The nurse would address the client's distress immediately and later include the event in the end-of-shift report to the oncoming nurse.
Page Ref: 2617-2618
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.B.15. Communicate care provided and needed at each transition in care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Communicate effectively with different individuals (team members, other care providers, patients, families, etc.) so as to minimize risks associated with handoffs among providers and across transitions in care. | Nursing Process: Implementation

Learning Outcome: 38.D. Analyze reporting as it relates to communication. Describe the process of telephone communication.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

3) The nurse is preparing to document care provided to a client during the day shift. The nurse notes that the client experienced an increased pain level while ambulating and thus required an extra dose of pain medication; took a shower; visited with family; and ate a small lunch. Which information is important to include during the oral end-of-shift reporting? **Select all that apply.**
A) The extra dose of pain medication
B) The client's visit with family
C) The client's response to ambulation
D) The last antibiotics given
E) The client's taking a shower
Answer: A, C
Explanation: A) The nurse should report any as-needed medications that were given and when they were last administered.
B) The client's visit with family need not be mentioned at change of shift but should be documented.
C) To best provide for the client's safety, the nurse should pass on information about the client's response to ambulation so that the oncoming staff can take fall precautions.
D) Antibiotic administration would be reflected on the medication administration record (MAR).
E) Taking a shower does not need to be reported, only documented.
Page Ref: 2617
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.15. Communicate care provided and needed at each transition in care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Communicate effectively with different individuals (team members, other care providers, patients, families, etc.) so as to minimize risks associated with handoffs among providers and across transitions in care. | Nursing Process: Implementation
Learning Outcome: 38.D. Analyze reporting as it relates to communication. Describe the handoff report.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

WwW.TeSt.Ws

4) Handoff communication, or the transfer of data during transitions in care, includes an opportunity to ask questions, clarify, and confirm the information being passed between sender and receiver. Which objective is the priority for ensuring effective communication during a client handoff?
A) Avoid lawsuits
B) Make sure all documentation is complete
C) Facilitate quality improvement
D) Ensure client safety
Answer: D
Explanation: A) Handoff communication may be scrutinized during a lawsuit, but avoiding litigation is not a primary objective.
B) Engaging in handoff communication can help a nurse determine whether all documentation related to a particular client's care is complete, but it is not the priority objective.
C) Analysis of handoff communication may be a quality improvement criterion, but it is not a primary objective.
D) Ineffective communication is the primary cause of sentinel events, making client safety the primary objective of the handoff communication process.
Page Ref: 2617
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.15. Communicate care provided and needed at each transition in care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Communicate effectively with different individuals (team members, other care providers, patients, families, etc.) so as to minimize risks associated with handoffs among providers and across transitions in care. | Nursing Process: Implementation
Learning Outcome: 38.D. Analyze reporting as it relates to communication. Describe the handoff report.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

5) The nurse on third shift is handing off clients to the nurse on first shift. Which statement is most important for the third shift nurse to report during this handoff?
A) "The client in room 312 is complaining about a headache unrelieved by pain medication. I am awaiting a call from the physician for orders."
B) "The client in room 313 ate a full meal several hours ago and is currently sleeping peacefully."
C) "The client in room 315 received an enema at 2100."
D) "The client in room 311 was transferred from room 212."
Answer: A
Explanation: A) A good change-of-shift report highlights significant changes in or concerns with a client's condition (e.g., persistent unrelieved headache), as well as any pending orders or requests for orders related to these changes or concerns.
B) A good change-of-shift report does not elaborate on meal consumption.
C) A good change-of-shift report does not elaborate on routine care, such as enema administration.
D) A good change-of-shift report is concise and does not elaborate on past client transfers.
Page Ref: 2617
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.15. Communicate care provided and needed at each transition in care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Communicate effectively with different individuals (team members, other care providers, patients, families, etc.) so as to minimize risks associated with handoffs among providers and across transitions in care. | Nursing Process: Implementation
Learning Outcome: 38.D. Analyze reporting as it relates to communication. Describe the handoff report.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

6) When the nurse receives a telephone order from the healthcare provider's office, which guidelines should the nurse use to ensure the order is correct? **Select all that apply.**
A) Ask the provider to repeat or spell out medication.
B) Read the order back to the provider.
C) Ask the provider to speak slowly.
D) Know agency policy for telephone orders.
E) Sign the provider's name and credentials.
Answer: A, B, C, D
Explanation: A) When receiving a telephone order from a provider, the nurse should ask the provider to repeat or spell out any medications.
B) The nurse should read the order back to the provider once the order is complete.
C) When receiving a telephone order from a provider, the nurse should ask the provider to speak slowly.
D) The nurse should know the agency's policy regarding telephone orders.
E) The nurse should not sign the provider's name and credentials; the nurse only transcribed the prescription, so the provider will need to countersign it within a time period prescribed by organizational policy.
Page Ref: 2618
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.B.15. Communicate care provided and needed at each transition in care. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Communicate effectively with different individuals (team members, other care providers, patients, families, etc.) so as to minimize risks associated with handoffs among providers and across transitions in care. | Nursing Process: Implementation
Learning Outcome: 38.D. Analyze reporting as it relates to communication. Describe the process of telephone communication.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

7) The nurse is providing care to a client diagnosed with end-stage renal disease. When organizing a care plan conference for this client, whom should the nurse invite to participate?
A) The client's family members
B) A psychiatrist
C) An oncologist
D) The hospital CEO
Answer: A
Explanation: A) Family members are an important part of the care plan conference, especially for clients who are unable to advocate for themselves.
B) It is unlikely that a psychiatrist would be part of the healthcare team.
C) It is unlikely that an oncologist would be part of the healthcare team.
D) It is unlikely that the hospital CEO would be part of the healthcare team.
Page Ref: 2619
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.15. Communicate care provided and needed at each transition in care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Quality and Safety: Communicate effectively with different individuals (team members, other care providers, patients, families, etc.) so as to minimize risks associated with handoffs among providers and across transitions in care. | Nursing Process: Planning
Learning Outcome: 38.D. Analyze reporting as it relates to communication. Summarize the care plan conference.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

8) Which categories are addressed when using the SBAR communication technique?
A) Scenario, Basics, Analysis, and Reaction
B) Situation, Background, Assessment, and Recommendation
C) Scenario, Background, Analysis, and Recommendation
D) Situation, Basics, Assessment, and Reaction
Answer: B
Explanation: A) Basics, analysis, and reaction are not parts of SBAR communication.
B) The SBAR technique provides a framework for safe, efficient communication between members of the healthcare team. In the first, or "Situation," step, the nurse provides a concise statement of the problem. In the second, or "Background," step, the nurse relates information relevant to the situation. In the third, or "Assessment," step, the nurse provides an analysis and consideration of options. Finally, in the fourth, or "Recommendation," step, the nurse provides a recommendation based on the relevant evidence.
C) Analysis in SBAR is a part of assessment.
D) Basics is not a part of SBAR communication.
Page Ref: 2617
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.15. Communicate care provided and needed at each transition in care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Communicate effectively with different individuals (team members, other care providers, patients, families, etc.) so as to minimize risks associated with handoffs among providers and across transitions in care. | Nursing Process: Implementation

Learning Outcome: 38.D. Analyze reporting as it relates to communication. Outline the SBAR technique of communication.
MNL LO: Demonstrate understanding of the concept of communication when documenting and reporting patient care.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 39 Managing Care

The Concept of Managing Care

1) The nurse works in a clinic environment that places great emphasis on cost control, increased efficiency, and customer satisfaction. For which type of healthcare system is the nurse providing care?
A) Functional method
B) Client-focused care
C) Case method
D) Managed care
Answer: D
Explanation: A) The functional method of care focuses on jobs to be completed and is task oriented.
B) Client-focused care is a delivery model that brings all services and care providers to the client.
C) The case method of care is a client-centered model in which one nurse is assigned to care for a group of clients during an 8- to 12-hour shift.
D) Managed care describes a healthcare system whose goals are lower costs, better outcomes, increased efficiency, and improved client outcomes.
Page Ref: 2621-2622
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
W W . T B S M . W S
Standards: QSEN Competencies: I.A.4. Examine how the safety, quality, and cost effectiveness of health care can be improved through the active involvement of patients and families. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Environmental health; Health Promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); Chronic disease management; Health care systems; Transcultural approaches to health; Family dynamics. | Nursing Process: Assessment
Learning Outcome: 39.1. Analyze frameworks for delivering care.
MNL LO: Analyze the concept of managing care and its application to nursing care.

2) A client being discharged after joint replacement surgery is confused because of having a case manager and a primary healthcare provider. Which response should the nurse make when the client asks, "Who is in charge?"

A) "I am in charge and manage your care."
B) "You are correct; the doctor is responsible for managing your care."
C) "A case manager coordinates everyone involved in your care to ensure your needs are met."
D) "The case manager delegates your care to the nurse."

Answer: C

Explanation: A) The nurse may be a case manager; however, a staff nurse is not the most likely individual in the hospital setting to be the case manager.

B) A physician does not participate in care by being a case manager.

C) The case manager is responsible for ensuring that all the client's healthcare needs are met in a cost-effective manner.

D) Case managers coordinate disciplines of care for the client and do not delegate any care to other professionals.

Page Ref: 2623

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Implementation

Learning Outcome: 39.1. Analyze frameworks for delivering care.

MNL LO: Analyze the concept of managing care and its application to nursing care.

3) The novice nurse wants to work in a facility where the nursing staff participates in clinical decisions to improve client outcomes. Which organizational model implements these practices?
A) Client-focused care
B) Differentiated practice
C) Managed care
D) Shared governance
Answer: D
Explanation: A) Client-focused care is a delivery model that brings all services and care providers to the client.
B) Differentiated practice is a system in which the best possible use of nursing personnel is based on their educational preparation and resultant skill sets. This model consists of specific job descriptions for nurses according to their education or training.
C) Managed care focuses on cost containment and consumer satisfaction.
D) Shared governance is an organizational model in which nursing staff are cooperative with administrative personnel to affect clinical decision-making and allocation of resources to improve client outcomes.
Page Ref: 2623
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV.A.2. Describe approaches for changing processes of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Environmental health; Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); Chronic disease management; Health care systems; Transcultural approaches to health; Family dynamics. | Nursing Process: Assessment
Learning Outcome: 39.1. Analyze frameworks for delivering care.
MNL LO: Analyze the concept of managing care and its application to nursing care.

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4) The nurse is appointed to a clinical-administrative task force studying critical staffing issues and care delivery models for the hospital. Which information about staffing choices and care delivery models should the task force consider? **Select all that apply.**

A) The number of clients assigned to each nurse.

B) Influence of shared governance on client care.

C) Staff qualifications and experience.

D) Impact of functional nursing on meeting clients' emotional needs.

E) Limited research on staffing ratios and client outcomes.

Answer: A, C

Explanation: A) The number of clients assigned to each nurse, or the client-nurse ratio, affects client outcomes.

B) Shared governance does not address staffing or client-nurse ratios.

C) There is research to support that the academic qualifications and experience impact client care.

D) Functional nursing is not likely a model to meet clients' emotional needs.

E) Studies have been done on staffing ratios and client outcomes. Research on this issue continues.

Page Ref: 2624

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: V.A.1. Examine human factors and other basic safety design principles as well as commonly used unsafe practices (such as, work-arounds and dangerous abbreviations). | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Environmental health; Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); Chronic disease management; Health care systems; Transcultural approaches to health; Family dynamics. | Nursing Process: Planning

Learning Outcome: 39.1. Analyze frameworks for delivering care.

MNL LO: Analyze the concept of managing care and its application to nursing care.

5) The nurse is applying for a job as a case manager for a managed care insurance organization. Which responsibility is associated with this role?
A) Providing home visits to clients
B) Independent treatment planning
C) Coordinating client care over time
D) Approving treatment decisions
Answer: C
Explanation: A) A case manager does not make home care visits.
B) A case manager is not responsible for planning a client's care.
C) Insurance-based case management is a labor-intensive activity that is provided typically by telephone, not home visits. Case management involves interprofessional teams that assume collaborative responsibility for planning and assessing needs. Case management involves coordinating, implementing, and evaluating care for groups of clients from preadmission through discharge or transfer and recuperation.
D) Approving treatment decisions is not a case management role.
Page Ref: 2622
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: Planning | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Planning

Learning Outcome: 39.1. Analyze frameworks for delivering care.
MNL LO: Analyze the concept of managing care and its application to nursing care.

6) Which concepts are essential when a nurse is managing the care of a client? **Select all that apply.**
A) Ethics
B) Advocacy
C) Informatics
D) Communication
E) Teaching and Learning
Answer: A, B, D, E
Explanation: A) Nurses need to provide client-centered care in accordance with the common ethical nursing values of being truthful, promoting good, maintaining fairness, and doing no harm.
B) Nurses work in a variety of healthcare settings with heterogeneous populations that need advocates to protect their rights. Nurse advocates empower and educate patients while managing their care.
C) Informatics is not an essential concept when managing a client's care.
D) Nurses direct communication within the collaborative team. They facilitate client interactions with team members and coordinate care activities. In addition, they familiarize clients with their conditions and any necessary procedures. They also listen to client concerns and answer client questions.
E) Nurses are primarily responsible for client teaching; as such, they lay groundwork essential for keeping clients healthy and reducing the costs of care. Nurses also play an important role in helping other staff members develop their skills, particularly when tasks are delegated to less experienced staff members.
Page Ref: 2626

Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.9. Communicate with team members, adapting own style of communicating to needs of the team and situation. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Effective strategies for communicating with different members of the health team, including patients and families, nurses, and other health professionals. | Nursing Process: Implementation
Learning Outcome: 39.2. Outline the relationship between managing care and other concepts.
MNL LO: Analyze the concept of managing care and its application to nursing care.

Exemplar 39.A Case Management

1) The nurse is helping with discharge planning for a client who needs extensive rehabilitation and is on a complicated medication schedule. The client and partner currently live with their eldest son, and the family is very involved in the client's care. The nurse would want to coordinate the client's daily care by including which individuals? **Select all that apply.**
A) Pharmacist
B) Client's children
C) Primary healthcare provider
D) Social worker
E) Client's partner
Answer: B, E
Explanation: A) The pharmacist would not be involved in daily care in most circumstances.
B) Effective discharge planning necessitates health team conferences and family conferences and gives the client, family, and healthcare professionals the opportunity to plan care and set goals. Involving the client's children would be important in this situation because of the complexity of the client's situation.
C) The physician would not be involved in daily care in most circumstances.
D) The social worker would not be involved in daily care in most circumstances.
E) Effective discharge planning necessitates health team conferences and family conferences and gives the client, family, and healthcare professionals the opportunity to plan care and set goals. Involving the client's partner would be important in this situation because of the complexity of the client's situation.
Page Ref: 2626

Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.8. Integrate the contributions of others who play a role in helping patient/family achieve health goals. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Teamwork: Effective strategies for communicating with different members of the health team, including patients and families, nurses, and other health professionals. | Nursing Process: Planning
Learning Outcome: 39.A. Analyze case management as it relates to managing care. Describe the purpose of case management and the role of the case manager.
MNL LO: Analyze the concept of managing care and its application to nursing care.

2) The nurse is caring for a preschool-age client with brain damage from a motor vehicle crash. The client has a tracheostomy, is ventilator-dependent, and will be discharged from the hospital into the family's care. The family wants to care for the child at home but does not have the resources for 24-hour care. Which action by the care manager is appropriate?
A) Making referrals to a variety of community-based agencies that can meet the family's needs
B) Telling the family that it is impossible to provide care at home
C) Arranging for the child to be sent to a long-term healthcare facility
D) Contacting local nurses in the community to provide the assistance that the family needs
Answer: A
Explanation: A) The referral process is a systematic problem-solving approach that helps clients use resources that meet their healthcare needs.
B) The nurse should not tell the family they cannot care for the client at home.
C) The nurse should not arrange for the child to be sent to a long-term care facility, because this does not reflect the family's wishes.
D) Contacting local nurses would not be an efficient way to manage this client's care.
Page Ref: 2627
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.6. Describe strategies to empower patients or families in all aspects of the health care process. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality & Safety: Communicate effectively with different individuals (team members, other care providers, patients, families, etc.) so as to minimize risks associated with handoffs among providers and across transitions in care. | Nursing Process: Implementation

Learning Outcome: 39.A. Analyze case management as it relates to managing care. Describe the purpose of case management and the role of the case manager.
MNL LO: Analyze the concept of managing care and its application to nursing care.

3) The nurse is caring for a client who had a total hip replacement 14 days ago. The client is preparing for discharge in a few days. The nurse facilitates a care conference with the primary healthcare provider, occupational therapist, physical therapist, and the client and family to develop a plan of care for the client prior to discharge. Which roles are being demonstrated by this nurse? **Select all that apply.**
A) Coordinator
B) Collaborator
C) Differentiated practitioner
D) Team leader
E) Expert
Answer: A, B
Explanation: A) The nurse is solving problems and planning care for the client by coordinating care with the other health team members who will participate in client care.
B) The nurse is solving problems and planning care for the client by collaborating with the other health team members who will participate in client care.
C) Differentiated practice involves nursing care from all levels of education and is not illustrated in this scenario.
D) The nurse is not responsible for how the members of the health team perform their jobs as a team leader would be.
E) All members of the team may be experts, but the level of expertise is not the role the nurse is exhibiting.
Page Ref: 2626
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: II.B.8. Integrate the contributions of others who play a role in helping patient/family achieve health goals. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality & Safety: Communicate effectively with different individuals (team members, other care providers, patients, families, etc.) so as to minimize risks associated with handoffs among providers and across transitions in care. | Nursing Process: Implementation
Learning Outcome: 39.A. Analyze case management as it relates to managing care. Describe the purpose of case management and the role of the case manager.
MNL LO: Analyze the concept of managing care and its application to nursing care.

4) The nurse working in an outpatient OB-GYN clinic is asked to assume the case management for the clinic's adolescent clients. Which skills will the nurse need to perform this work?
A) Critical thinking
B) Physical assessment
C) Relaxation training
D) Accounting
Answer: A
Explanation: A) Critical thinking skills are crucial to the development of a well-coordinated care plan and its execution.
B) The role of case manager may not include performing physical assessments on the client.
C) Relaxation training skills are not a part of care coordination.
D) Accounting skills are not a part of care coordination.
Page Ref: 2627
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.16. Participate in designing systems that support effective teamwork. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Personal and Professional Development: Apply decision-making skills, particularly in the context of uncertainty and ambiguity. | Nursing Process: Planning
Learning Outcome: 39.A. Analyze case management as it relates to managing care. Describe the purpose of case management and the role of the case manager.
MNL LO: Analyze the concept of managing care and its application to nursing care.

5) The nurse is reviewing client records to determine which clients are good candidates for case management. Which client would the nurse choose as having the highest priority for assigning a case manager?

A) A newborn who was diagnosed with cerebral palsy
B) A pregnant client with three other children
C) A school-age child who was diagnosed with pneumonia
D) An older adult who has been diagnosed with hypertension
Answer: A
Explanation: A) A newborn diagnosed with cerebral palsy has a congenital condition that will require lifelong care.
B) The pregnant client does not appear to be at risk from this description.
C) The school-age child has an acute condition, not a chronic condition.
D) The older adult has a chronic condition, but in the absence of other complicating factors, this one condition would not require case management.
Page Ref: 2628
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.11. Examine nursing roles in assuring coordination, integration, and continuity of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Teamwork: Clarify roles and integrate the contributions of others who play a role in helping the patient/family achieve health goals. | Nursing Process: Planning
Learning Outcome: 39.A. Analyze case management as it relates to managing care. Describe the purpose of case management and the role of the case manager.
MNL LO: Analyze the concept of managing care and its application to nursing care.

6) The nurse is managing the care of an older adult client who is near the end of life but still has treatment options available. The treatment options could potentially be painful and expensive, and they would only extend the client's life approximately 2 months. Which topic should the nurse include during initial discussions with the client and family?

A) The need for hospice care for the client

B) Referral for grief counseling for the family

C) Reasons why the client should remain in the hospital until death

D) The client's health and impending mortality

Answer: D

Explanation: A) Hospice care should be presented as an option, but only if the client chooses not to receive additional treatment.

B) Grief counseling for the family would come at a later appointment, not during initial discussions.

C) The client should be given the choice of where they want to die, not be encouraged to remain in the hospital until death.

D) When providing case management for a client near the end of life, the case manager's first step in ensuring that the client's wishes are met is to speak honestly to the client about their health and impending mortality.

Page Ref: 2629

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: II.B.1. Elicit patient values, preferences, and expressed needs as part of clinical interview, implementation of care plan and evaluation of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Communicate information effectively; listen openly and cooperatively. | Nursing Process: Planning

Learning Outcome: 39.A. Analyze case management as it relates to managing care. Describe the purpose of case management and the role of the case manager.

MNL LO: Analyze the concept of managing care and its application to nursing care.

Exemplar 39.B Cost-Effective Care

1) An older adult client tells the nurse, "I am worried about how I will pay for my hospital bill." The client is being discharged, is being referred to home healthcare, and the new plan of care involves extremely expensive drugs. Which response by the nurse is appropriate?
A) "You need to focus on recovering and not worry about finances."
B) "I'll have someone from the business office come and set up your payment plan."
C) "Don't worry. I'm sure everything will work out okay."
D) "Much of your care will be covered by Medicare."
Answer: D
Explanation: A) Ignoring the client's concerns by telling him not to worry is not therapeutic communication and does little, if anything, to confront the client's concerns.
B) Passing the concern to the business office does not address the client's concerns.
C) The client is worrying and there is no guarantee that everything will work out.
D) Medicare provides a health insurance program for adults over the age of 65. A large portion of this client's bill will be covered by Medicare.
Page Ref: 2630
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.4. Examine how the safety, quality and cost effectiveness of health care can be improved through the active involvement of patients and families. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Promote and accept the patient's emotions; accept and respond to distress in patient and self; facilitate hope, trust, and faith. | Nursing Process: Implementation
Learning Outcome: 39.B. Analyze cost-effective care as it relates to managing care. Summarize payment sources in the United States.
MNL LO: Analyze the concept of managing care and its application to nursing care.

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2) The nurse is caring for an adult client from Canada who has come to the United States for a serious neurologic surgery. The client tells the nurse, "I came to this country so that I would receive the care I need." For which reason did the client most likely make that statement?
A) The United States has many choices about healthcare.
B) The United States has a nationalized healthcare system.
C) Healthcare rationing in the United States decreases cost.
D) There is very little competition in healthcare in the United States.
Answer: A
Explanation: A) Americans with health insurance have more of a choice about their healthcare than do other nations of the world.
B) Canada has a nationalized healthcare system.
C) There is no evidence of healthcare rationing in the United States.
D) Most other countries do not allow for competition in healthcare, but the United States does.
Page Ref: 2630
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.6. Describe strategies to empower patients or families in all aspects of the health care process. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Context and Environment: Environmental health; Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); Chronic disease management; Health care systems; Transcultural approaches to health; Family dynamics. | Nursing Process: Evaluation
Learning Outcome: 39.B. Analyze cost-effective care as it relates to managing care. Describe the international perspective of healthcare.

MNL LO: Analyze the concept of managing care and its application to nursing care.

3) An instructor is teaching the class about cost-conscious nursing practice. The instructor knows that the students understand this concept when the students make which statements? **Select all that apply.**

A) "Nurses must search for more efficient ways to deliver nursing care."
B) "Careful use of supplies will reduce waste and save money."
C) "I do have to take shortcuts every now and then."
D) "There are insufficient healthcare workers to meet the need right now."
E) "A new emphasis has been placed on health promotion and disease prevention."

Answer: A, B, E

Explanation: A) Nurses at all levels face significant pressures to become more cost conscious.
B) Nurses can be more cost-conscious by carefully using supplies.
C) Taking shortcuts can lead to mistakes, and client care should never be compromised.
D) It is true that there are too few healthcare workers to meet needs, but this does not contribute to cost-conscious nursing care.
E) Nurses can be more cost-conscious by placing emphasis on health promotion and disease prevention.

Page Ref: 2630
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.10. Demonstrate commitment to team goals. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Context and Environment: Environmental health; Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); Chronic disease management; Health care systems; Transcultural approaches to health; Family dynamics. | Nursing Process: Evaluation

Learning Outcome: 39.B. Analyze cost-effective care as it relates to managing care. Summarize the economics of nursing.
MNL LO: Analyze the concept of managing care and its application to nursing care.

4) A client recovering from an emergency appendectomy is a citizen of a foreign country. The client asks the nurse to explain why the United States has chosen such a different healthcare reimbursement system from other Western countries. Which American value could the nurse mention to explain the system in this country?
A) Rejection of government in individual lives
B) Lack of finances to purchase insurance
C) Skepticism about markets and competition
D) Universality
Answer: A
Explanation: A) How a society views the role of government in people's lives influences the development of its healthcare systems and policies. The United States has not adopted a nationalized or socialized form of medicine as the mode of healthcare delivery.
B) A lack of finances to purchase insurance is not an American value.
C) The U.S. system is based on market competition.
D) In the United States personal choice is valued over universality.
Page Ref: 2630
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.4. Examine how the safety, quality and cost effectiveness of health care can be improved through the active involvement of patients and families. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Environmental health; Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); Chronic disease management; Health care systems; Transcultural approaches to health; Family dynamics. | Nursing Process: Implementation
Learning Outcome: 39.B. Analyze cost-effective care as it relates to managing care. Describe the international perspective of healthcare.
MNL LO: Analyze the concept of managing care and its application to nursing care.

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5) The nurse working in a large municipal hospital is appointed to a task force whose focus is addressing nursing shortages. Which factor should the task force consider?
A) Nurses are only used for clinical services.
B) Nursing shortages contribute to salary fluctuations.
C) Only licensed nurses are used for all nursing duties.
D) Reductions in nursing staff encourage nurses to remain in the profession.
Answer: B
Explanation: A) Nurses are also now being hired in new roles that do not include clinical services, such as case management for managed care organizations.
B) When nursing shortages occur, employers must increase wages in order to hire and retain staff. As the positions are filled, employers slow the rate at which they increase wages, causing salary fluctuations.
C) Nurses have been replaced by unlicensed assistive personnel (UAP) as a cost-containment measure, and many nursing duties are now performed by UAPs.
D) As a result of reductions in nursing staff, some nurses, feeling they can no longer provide quality healthcare, experience disillusionment and leave the profession.
Page Ref: 2633
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.10. Identify system barriers and facilitators of effective team functioning. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Environmental health; Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); Chronic disease management; Health care systems; Transcultural approaches to health; Family dynamics. | Nursing Process: Planning

Learning Outcome: 39.B. Analyze cost-effective care as it relates to managing care. Summarize the economics of nursing.
MNL LO: Analyze the concept of managing care and its application to nursing care.

6) Which action will allow facilities to better track the cost effectiveness of various nursing actions and allocate nursing resources most efficiently?
A) Bundling nursing care
B) Quantifying nursing care
C) Rationing nursing care
D) Increasing demand for nursing care
Answer: B
Explanation: A) Bundling nursing care does not allow facilities to track the cost of nursing actions.
B) Quantifying nursing care will help control costs by ensuring that clients pay only for the exact level of nursing care they require. It will also provide useful data that allows facilities and providers to better track the cost effectiveness of various nursing actions, as well as allocate nursing resources in the most efficient way possible.
C) Rationing nursing care is related to supply and demand, not tracking nursing actions.
D) Increasing the demand for nursing care would not facilitate more efficient tracking of nursing actions.
Page Ref: 2633
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.10. Identify system barriers and facilitators of effective team functioning. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Environmental health; Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); Chronic disease management; Health care systems; Transcultural approaches to health; Family dynamics. | Nursing Process: Planning

Learning Outcome: 39.B. Analyze cost-effective care as it relates to managing care. Outline factors influencing the provision of healthcare.
MNL LO: Analyze the concept of managing care and its application to nursing care.

7) The movement from a retrospective payment system to a prospective payment system using a diagnosis-related group may have which unintentional consequence for hospitals trying to contain their costs?
A) Hospitals are now admitting more clients than previously.
B) Clients are sent home from the hospital as soon as possible.
C) Physicians order as many tests as needed to correctly diagnose the client's condition.
D) Nurses are encouraged to follow safety protocols to reduce complications.
Answer: B
Explanation: A) Hospitals are now admitting fewer clients, not more clients.
B) It has shortened hospital stays, so clients are sent home from the hospital as soon as possible to avoid the expenditures a prolonged stay generates.
C) The movement to a prospective payment system has resulted in healthcare agencies choosing to withhold borderline necessary tests and procedures, not order as many tests as needed to correctly diagnose the client's condition.
D) Nurses are encouraged to follow safety protocols regardless of the payment system.
Page Ref: 2632
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.10. Identify system barriers and facilitators of effective team functioning. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Environmental health; Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); Chronic disease management; Health care systems; Transcultural approaches to health; Family dynamics. | Nursing Process: Planning

Learning Outcome: 39.B. Analyze cost-effective care as it relates to managing care. Describe cost-containment strategies.
MNL LO: Analyze the concept of managing care and its application to nursing care.

Exemplar 39.C Delegation

1) The nurse delegates vital signs and daily weights of assigned clients to the unlicensed assistive personnel (UAP) on duty. For which reason should the nurse assess each client throughout the shift?
A) The UAP cannot report to the next shift.
B) The UAP is not trustworthy.
C) The nurse maintains the authority to care for the clients.
D) The nurse remains accountable for the clients' care.
Answer: D
Explanation: A) The nurse could take a report from the UAP and report that to the next shift.
B) The UAP may be untrustworthy, however this is not the reason for the nurse to assess the clients throughout the shift.
C) The nurse transfers the authority for the delegated care to the UAP.
D) The nurse remains accountable for the care of clients during delegation to the UAP.
Page Ref: 2635
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Teamwork: Clarify roles and integrate the contributions of others who play a role in helping the patient/family achieve health goals. | Nursing Process: Planning
Learning Outcome: 39.C. Analyze delegation as it relates to managing care. Summarize principles of delegation.

MNL LO: Analyze the concept of managing care and its application to nursing care.

2) A postoperative client is transferred to the medical-surgical unit from the intensive care unit (ICU). The client asks the assigned nurse why unlicensed assistive personnel (UAP) help with range-of-motion exercises. Which response should the nurse make?

A) "Your condition has improved, so I delegated that part of your care to the UAP."
B) "You do not need me to ambulate you."
C) "The charge nurse made the decision to have the UAP assist you when walking."
D) "I assigned all of your care to the UAP."

Answer: A

Explanation: A) An assignment of care is made to a qualified individual (the RN), who then may delegate parts of that care to a UAP.

B) Saying that the client does not need the nurse is not the best approach; it is better to explain that the client has improved to the point where the UAP can assist with certain tasks.

C) The charge nurse does not make the assessment to delegate to the UAP; the RN assigned to the care of the client is the decision maker.

D) The nurse would not assign care to the UAP, but rather, delegate certain tasks to the UAP.

Page Ref: 2635

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: II.B.16. Participate in designing systems that support effective teamwork. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Clarify roles and integrate the contributions of others who play a role in helping the patient/family achieve health goals. | Nursing Process: Implementation

Learning Outcome: 39.C. Analyze delegation as it relates to managing care. Summarize principles of delegation.

MNL LO: Analyze the concept of managing care and its application to nursing care.

3) The nurse is working on a medical-surgical unit that is short staffed due to a calloff. The manager of the unit was unable to replace the nurse, so the extra clients were assigned to the remaining nurses. The manager was able to get the help of unlicensed assistive personnel (UAP) from the house pool to help on the unit. Which action by the nurses would ensure effective care for the client?
A) Delegate vital signs and weights to the UAP.
B) Explain to the manager that care may be compromised if another nurse does not work the shift.
C) Tell the clients their care will be sparse.
D) Assign care of invasive lines to the UAP.
Answer: A
Explanation: A) The nurses would delegate to the UAP tasks such as taking and recording vital signs and weights to ensure that all clients receive appropriate care.
B) The goal for the unit is to meet the needs of the clients; complaining to the manager will not accomplish this.
C) Telling the clients their care will be sparse is inappropriate.
D) UAPs are not assigned care, they are delegated tasks, and nurses should never delegate the task of care of invasive lines to the UAP.
Page Ref: 2636
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.16. Participate in designing systems that support effective teamwork. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Clarify roles and integrate the contributions of others who play a role in helping the patient/family achieve health goals. | Nursing Process: Implementation
Learning Outcome: 39.C. Analyze delegation as it relates to managing care. Summarize principles of delegation.
MNL LO: Analyze the concept of managing care and its application to nursing care.

4) The nurse is caring for several medical-surgical clients. The nurse has delegated skin care of an incontinent client to a new unlicensed assistive personnel (UAP) on the unit. Which action by the nurse will improve effectiveness of the client care provided?
A) Ask the client if the care was appropriate.
B) Ask the UAP if the care was given.
C) Demonstrate the appropriate care needed and have the UAP give a return demonstration.
D) Closely observe the UAP each time the care is given.
Answer: C
Explanation: A) The nurse could possibly alarm the client by asking the client if care was appropriate.
B) The nurse would reassess the client's skin later rather than asking the UAP if the task was done.
C) The nurse would show the UAP the exact procedure the first time to avoid any confusion and then have the UAP give a return demonstration to ensure the UAP knows how to properly perform the procedure.
D) Closely observing the UAP each time defeats the purpose of delegation.
Page Ref: 2636
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.16. Participate in designing systems that support effective teamwork. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Clarify roles and integrate the contributions of others who play a role in helping the patient/family achieve health goals. | Nursing Process: Implementation

Learning Outcome: 39.C. Analyze delegation as it relates to managing care. Summarize principles of delegation.
MNL LO: Analyze the concept of managing care and its application to nursing care.

5) The nurse is working on a unit with unlicensed assistive personnel (UAP). One nurse refuses to use the UAP and is consistently leaving nursing tasks for the next shift that have yet to be completed. For which reason is the nurse avoiding the use of the UAP to assist with client care?
A) Avoidance of responsibility
B) Overdependence on others
C) The belief that no one else can perform a task as well as the nurse can
D) The state nurse practice act
Answer: C
Explanation: A) The nurse is accepting too much responsibility rather than too little.
B) The nurse who refuses to delegate care is not being overly dependent.
C) One barrier to delegation is the belief that nobody else is capable of getting the job done for the client.
D) The state nurse practice act would be considered an environmental barrier.
Page Ref: 2639
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.16. Participate in designing systems that support effective teamwork. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Teamwork: Clarify roles and integrate the contributions of others who play a role in helping the patient/family achieve health goals. | Nursing Process: Assessment
Learning Outcome: 39.C. Analyze delegation as it relates to managing care. Outline factors affecting delegation.
MNL LO: Analyze the concept of managing care and its application to nursing care.

6) The nurse delegated to an unlicensed assistive personnel (UAP) the task of assisting a client with a simple dressing change. The client was formerly able to do the procedure, but because of painful arthritis is now unable to perform the redressing. The UAP has done this procedure before. Which action should the nurse take?
A) Ask the UAP to report to the nurse immediately anything unusual, such as bleeding or infection.
B) The nurse should demonstrate the steps of the procedure to the UAP.
C) Make the client do most of the procedure and report the expected output.
D) The UAP should do health teaching while performing the procedure.
Answer: A
Explanation: A) The nurse delegated a specific legal task to the UAP, which is within the scope of the UAP's ability. The nurse established the particular parameters outside of which immediate notification is requested.
B) If the UAP has done the procedure before, the nurse should not need to demonstrate it.
C) If in pain, the client should not have to do any of the procedure.
D) Health teaching is outside of the scope of practice for the UAP.
Page Ref: 2636
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Clarify roles and integrate the contributions of others who play a role in helping the patient/family achieve health goals. | Nursing Process: Implementation

Learning Outcome: 39.C. Analyze delegation as it relates to managing care. Outline the delegation process.
MNL LO: Analyze the concept of managing care and its application to nursing care.

7) The nurse-supervisor is encouraging nurses to delegate responsibilities whenever possible. Which criteria are used to determine tasks that can be delegated? **Select all that apply.**

A) Does the delegate have the appropriate skills to perform the task safely?
B) How busy are you?
C) Is the client frequently complaining?
D) Does the task require client education?
E) Is the task unpleasant?

Answer: A, D

Explanation: A) Only tasks that are within the delegate's scope of practice and that the delegate has the skills to perform safely should be delegated.
B) The nurse's busyness may point out the need for delegation, but it does not define which tasks may be delegated.
C) The behavior of the client is not a criterion for delegation.
D) Tasks that require client education should never be delegated.
E) The unpleasant nature of the task is not a criterion for delegation.

Page Ref: 2636
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.16. Participate in designing systems that support effective teamwork. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Teamwork: Clarify roles and integrate the contributions of others who play a role in helping the patient/family achieve health goals. | Nursing Process: Planning
Learning Outcome: 39.C. Analyze delegation as it relates to managing care. Outline the delegation process.

MNL LO: Analyze the concept of managing care and its application to nursing care.

8) An experienced delegator is mentoring a newly appointed nurse in the hospital. The new nurse states, "I am hesitant to delegate tasks to unlicensed assistive personnel (UAP) because I am afraid they will not be done correctly." Which response by the experienced delegator is appropriate?
A) Direct to not delegate any tasks unless being completely confident.
B) Direct to clearly identify the task and expectations and then to monitor the delegate's progress.
C) Explain that delegation often results in a decrease in job satisfaction.
D) Remind that the responsibility of the nurse is to perform all care independently.
Answer: B
Explanation: A) An appropriate environment supports delegation.
B) The key to retaining control is to clearly identify the task and expectations and then to monitor the delegate's progress and provide feedback.
C) If one is able to delegate some routine tasks to others, then job satisfaction should increase because of increased opportunities.
D) Although this is a typical concern of inexperienced and insecure delegators, following the delegation guidelines can increase confidence in the process. It is not an expectation for the nurse to provide all care independently.
Page Ref: 2636
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.16. Participate in designing systems that support effective teamwork. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Clarify roles and integrate the contributions of others who play a role in helping the patient/family achieve health goals. | Nursing Process: Implementation
Learning Outcome: 39.C. Analyze delegation as it relates to managing care. Outline factors affecting delegation.
MNL LO: Analyze the concept of managing care and its application to nursing care.

Exemplar 39.D Leadership and Management

1) A nursing supervisor has been told to ensure that the hospital's new electronic records system is properly implemented on the nursing unit. Which actions by the supervisor are the best use of exercising the managerial role? **Select all that apply.**
A) Creating a "buddy" system that pairs staff members who are more technologically comfortable with staff members who may require more assistance with the new system
B) Providing regular training sessions in the new system
C) Informing staff that the new system is optional
D) Establishing a regular spot check of each staff member's effective use of the system
E) Continuing to use paper records until the staff is completely comfortable with the new system
Answer: A, B, D
Explanation: A) The manager's role includes choosing the means by which to achieve goals, assigning and coordinating tasks, developing and motivating staff, and evaluating outcomes and providing feedback. A buddy system would be helpful
B) Training sessions would be applicable to achieve the directive.
C) The manager should not undermine the organizational goals and objectives by saying the new system is optional.
D) Checking the staff's use of the system is an approach that would support the directive.
E) Using paper records would undermine the organizational goals and objectives.
Page Ref: 2641
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the health care team. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Impact of team functioning on safety and quality of care, and how authority gradients influence teamwork and patient safety. | Nursing Process: Implementation
Learning Outcome: 39.D. Analyze leadership and management as they relate to managing care. Outline the four functions of management.
MNL LO: Analyze the concept of managing care and its application to nursing care.

2) The nurse manager is interested in initiating self-scheduling on the medical-surgical unit. Which actions will the nurse manager take when planning this initiative? **Select all that apply.**

A) Establish objectives (goals).
B) Evaluate the present situation and predict future trends and events.
C) Formulate a planning statement (means).
D) Coordinate the work to be done.
E) Convert the plan into an action statement.

Answer: A, B, C, E

Explanation: A) The planning process includes establishing objectives (goals).
B) The planning process includes evaluating the present situation and predicting future trends and events.
C) The planning process includes formulating a planning statement (means).
D) Coordination is part of organization, not planning.
E) The planning process includes converting the plan into an action statement.

Page Ref: 2643-2645
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the health care team. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Teamwork: Impact of team functioning on safety and quality of care, and how authority gradients influence teamwork and patient safety. | Nursing Process: Planning
Learning Outcome: 39.D. Analyze leadership and management as they relate to managing care. Outline the four functions of management.
MNL LO: Analyze the concept of managing care and its application to nursing care.

3) The nursing supervisor is asked to help manage the switch from paper to electronic records. Which standard managerial steps will the nursing supervisor take to initiate this process? **Select all that apply.**

A) Planning
B) Experimenting
C) Organizing
D) Criticizing
E) Synthesizing

Answer: A, C

Explanation: A) The nurse manager plans and develops specific goals and objectives for their area of responsibility.
B) Experimenting is not a standard managerial function.
C) Organizing is the process of coordinating the work to be done.
D) Criticizing is not a standard managerial function.
E) Synthesizing is not a standard managerial function.

Page Ref: 2643-2644
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the health care team. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Teamwork: Impact of team functioning on safety and quality of care, and how authority gradients influence teamwork and patient safety. | Nursing Process: Planning
Learning Outcome: 39.D. Analyze leadership and management as they relate to managing care. Outline the four functions of management.
MNL LO: Analyze the concept of managing care and its application to nursing care.

4) A supervisor on a medical-surgical unit excels at scheduling staff and allocating resources. However, when new policies are being implemented, the supervisor has great difficulty getting staff cooperation. Based on this data, for which reason is the supervisor considered a manager and not a leader?
A) A leader clarifies the organizational structure.
B) A leader uses interpersonal skills to accomplish goals.
C) A leader always assigns and coordinates tasks.
D) A leader must use contingency planning.
Answer: B
Explanation: A) Managers are more apt to clarify the organizational structure.
B) Leaders use interpersonal skills to influence others to accomplish specific goals, and this supervisor has trouble influencing others.
C) Managers assign and coordinate tasks.
D) Managers use contingency planning.
Page Ref: 2641
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the health care team. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Teamwork: Impact of team functioning on safety and quality of care, and how authority gradients influence teamwork and patient safety. | Nursing Process: Assessment
Learning Outcome: 39.D. Analyze leadership and management as they relate to managing care. Differentiate managers from leaders.
MNL LO: Analyze the concept of managing care and its application to nursing care.

5) The emergency department staff is overwhelmed when multiple victims arrive from an explosion at a downtown factory. Which leadership style would be most beneficial for the charge nurse to adopt in this situation to provide nursing care most efficiently to the incoming victims?
A) Autocratic
B) Democratic
C) Laissez-faire
D) Bureaucratic
Answer: A
Explanation: A) An autocratic leader is most effective when urgent decisions must be made in a critical situation. The autocratic leader gives orders and directions to the group to care for the victims most efficiently.
B) A democratic leader encourages group discussion and decision making, which is not appropriate for this situation.
C) A laissez-faire leader takes a hands-off approach, which may cause a lack of cooperation and coordination.
D) A bureaucratic leader relies on rules, policies, and procedures to direct the work.
Page Ref: 2642
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.9. Communicate with team members, adapting own style of communicating to the needs of the team and situation. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Teamwork: Adapt communication to the team and situation to share information or solicit input; Initiate requests for help when appropriate. |
Nursing Process: Planning

Learning Outcome: 39.D. Analyze leadership and management as they relate to managing care. Outline classic and contemporary leadership theories.
MNL LO: Analyze the concept of managing care and its application to nursing care.

6) A nurse manager has created a culture of empowerment among the nursing staff. The nursing staff feels that they have the information, support, and resources to perform their tasks efficiently and effectively, and they also have opportunities for advancement, continued education, and input into nursing policies. Which outcome should the nurse manager expect?
A) The nurses will feel the need to find jobs elsewhere.
B) The nurses will be more committed to the institution.
C) The nurses will work independently without help from others.
D) The nurses will effectively avoid conflict.
Answer: B
Explanation: A) The nurses would usually prefer to remain in their current position than try to find a job elsewhere.
B) Empowered employees will be more committed to the institution, more effective in their roles, and more confident in their abilities.
C) An empowered team of nurses will work together more effectively, not work independently.
D) An empowered team of nurses will not necessarily avoid conflict, but they will know how to manage conflict more effectively.
Page Ref: 2643
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the health care team. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Teamwork: Impact of team functioning on safety and quality of care, and how authority gradients influence teamwork and patient safety. | Nursing Process: Evaluation

Learning Outcome: 39.D. Analyze leadership and management as they relate to managing care. Describe selected principles of management.
MNL LO: Analyze the concept of managing care and its application to nursing care.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 40 Professional Behaviors

Professional Behaviors

1) The nurse must start an IV for a toddler in the emergency department. The toddler is accompanied by a parent. The parent asks the nurse, "Can I stay with my child and comfort him?" Which response by the nurse is best?
A) "Yes, it would be helpful for you to stay and comfort your child."
B) "We do this all the time, so don't worry. I will come get you when we are done starting the IV."
C) "Be ready to hold your child down when I tell you to."
D) "It doesn't take long to start an IV, so there's no need for you to stay for the procedure."
Answer: A
Explanation: A) An important part of nurse competency is knowing what procedures to follow when performing skills. For example, when initiating an IV on a pediatric client, procedure dictates that the nurse should always seek assistance from the client's parent if the parent is willing and capable of offering assistance. If the parent agrees to offer assistance, the nurse can then provide appropriate teaching.
B) Telling the parent not to worry is both pointless and dismissive of the parent's concerns.
C) Instructing the parents to hold down the child without giving them a choice is inappropriate; many parents do not want to participate in activities that cause pain to their child.
D) It is inappropriate for the nurse to say that the procedure won't take long, because the nurse does not know how much time the procedure will actually require.

Page Ref: 2648
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.4. Recognize contributions of other individuals and groups in helping patient/family achieve health goals. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; Collaborate and work cooperatively with others; Resolve conflicts; Respond to moral and ethical challenges. | Nursing Process: Implementation
Learning Outcome: 40.1. Analyze the components of professionalism within the practice of nursing.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

2) The nurse forgets to return a client's bed to the low position after performing a bed bath. When a colleague points this out, the nurse states, "I should have returned the bed to the low position. Thank you for pointing out my error." With which characteristic is the nurse's response most consistent?
A) Compassion
B) Integrity
C) Fidelity
D) Justice
Answer: B
Explanation: A) Compassion is an awareness of and concern for the suffering of others.
B) Integrity involves adherence to a strict moral or ethical code. Nurses demonstrate integrity in various ways, such as by accepting feedback as a tool for improving their delivery of client care and by maintaining accountability for their actions and freely admitting when they make mistakes. By admitting to an error, this nurse is demonstrating integrity.
C) Fidelity means to be faithful to agreements and promises.
D) Justice has to do with being fair.
Page Ref: 2650
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: II.B.3. Act with integrity, consistency and respect for differing views. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; Be open and nonjudgmental. | Nursing Process: Assessment
Learning Outcome: 40.1. Analyze the components of professionalism within the practice of nursing.

MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

3) The nurse is caring for a critically ill infant in the neonatal intensive care unit (NICU). The infant's parents ask whether the child's 3-year-old sibling can visit. Small children are not permitted to visit the NICU because of the risk of infection to the infants on the unit. Which action by the nurse best demonstrates a compassionate response?

A) Seek permission from unit management and the neonatologist to allow the sibling to visit
B) Offer to make counseling available to the sibling
C) Tell the parents that visiting is not permitted and offer to take pictures of the client
D) Tell the parents to bring the sibling in to visit in the middle of the night

Answer: A

Explanation: A) Compassion, or awareness of and concern about other individuals' suffering, is an important component of professionalism. Nurses demonstrate compassion when they recognize a client's need and respond appropriately to meet that need. In this situation, although the nurse would realize that certain rules are in place for the protection of clients, the nurse would also recognize the need for compassion. Of the options provided, the most appropriate way to demonstrate compassion would be to seek permission to allow the sibling to visit and see that the infant is alive and being cared for.

B) Offering counseling may or may not be an effective means of assisting the family.

C) Telling the parents what the rules of the unit are will only increase the family's frustration when they are looking to the nurse for assistance.

D) The nurse would not make the decision without the permission of the management team.

Page Ref: 2650

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.B.8. Remove barriers to presence of families and other designated surrogates based on patient preferences. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Be open to others' ideas; Show humility, mutual trust, empathy, support, and a capacity for grace. | Nursing Process: Implementation

Learning Outcome: 40.1. Analyze the components of professionalism within the practice of nursing.

MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

4) The nurse overhears two colleagues disparaging a client on a public elevator. Which action by the nurse is most appropriate?
A) Immediately ask the nurses to stop talking about clients in public.
B) Report the nurses' behavior to the unit manager.
C) Wait and speak to the nurses about their behavior in a private place.
D) Report the nurses' behavior to the hospital's risk manager.
Answer: C
Explanation: A) If the first nurse were to confront the two colleagues in the elevator, this conversation could be overheard by others.
B) The nurse could report the incident to the unit manager, but it would be better for the nurse to personally confront the two colleagues in a professional way. If this isn't possible, then notifying the nurse manager would be the next step.
C) Nursing integrity ensures that patients' rights are respected in the healthcare setting. The first nurse should wait and speak to the other nurses privately about the breach of confidentiality.
D) The risk manager is only involved in situations in which there is an injury to a staff member or client.
Page Ref: 2650
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Codes of ethics, regulatory and professional standards, ethical decision-making models; Scope of practice considerations; Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Implementation
Learning Outcome: 40.1. Analyze the components of professionalism within the practice of nursing.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

5) A hospital's nursing staff is deciding whether to unionize. The hospital CFO tells a nurse supervisor to make sure all leaders of the unionization effort are scheduled for client care during union meetings. Which actions by the nurse supervisor are appropriate? **Select all that apply.**
A) Schedule the organizers for client care during union meeting times.
B) Schedule the organizers for client care according to clinical staffing needs.
C) Reprimand the staff nurses for their attempts to unionize.
D) Continue to implement the usual staffing procedures.
E) Discuss the need for professional nursing integrity with the CFO.
Answer: B, D, E
Explanation: A) Scheduling the organizers for client care during the union meeting times is an abuse of power.
B) Client care is the priority and staffing needs take priority.
C) It is an abuse of power to reprimand the nurses for their attempt to unionize.
D) Staffing needs to be planned according to client needs.
E) The need for professional nursing integrity should be discussed with the CFO.
Page Ref: 2652
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.9. Explain how authority gradients influence teamwork and patient safety. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Choose communication styles that diminish the risks associated with authority gradients among team members to accomplish care, assert one's own views, and minimize risks associated with handoffs among providers and across transitions in care. | Nursing Process: Implementation
Learning Outcome: 40.3. Analyze the components of unprofessional behaviors.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

6) The nurse has just received the shift report for a 12-hour shift. As the nurse is preparing to enter a client's room, the nurse overhears a coworker telling an offensive joke with a sexual undertone to the client. Which action by the nurse is appropriate?
A) Tell the coworker, in private, that such conduct is offensive and not professional.
B) Ignore the coworker and walk away.
C) Report the incident to the unit manager.
D) Ask to be scheduled on a different shift than this coworker.
Answer: A
Explanation: A) Nurses must develop assertiveness skills to deter sexual harassment in the workplace. Privately telling the coworker to stop, and explaining why, is the first step in putting an end to the situation.
B) Ignoring the coworker's behavior does not address the situation in an assertive manner.
C) Reporting the incident to the nurse manager would be an appropriate second step if the behavior doesn't stop after the nurse's initial discussion with the coworker.
D) Asking to be scheduled opposite this individual does not address the situation in an assertive manner.
Page Ref: 2652
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.7. Discuss effective strategies for communicating and resolving conflict. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Threats to the integrity of relationships, and the potential for conflict and abuse. | Nursing Process: Implementation
Learning Outcome: 40.3. Analyze the components of unprofessional behaviors.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

7) In which situation would the nurse's actions most likely be classified as intimidation?
A) When addressing a client, the nurse states, "I can't overemphasize how important it is that you stick with the treatment plan."
B) When addressing a coworker, the nurse states, "Your behavior is a violation of hospital policy. If you keep it up, I'll be forced to notify your supervisor."
C) When addressing a client, the nurse states, "It's essential that you take this medication at the same time each day. If you don't, your symptoms will likely intensify."
D) When addressing a coworker, the nurse states, "You'd best think twice about doing that again, or you might be sorry."
Answer: D
Explanation: A) Telling a client that you can't overstate the importance of treatment is not intimidation because it does not involve the threat of retribution.
B) A more suitable, less intimidating approach would be to tell the coworker why the behavior is unacceptable and ask him or her to stop; if the coworker refuses to do so, approaching the supervisor would be an appropriate next step.
C) Explaining that failure to take a medication as prescribed may result in a worsening of symptoms is not intimidation; here, rather than threatening retribution, the nurse is providing education about the chosen pharmacological therapy.
D) Intimidation is bullying, threatening, or forcing someone who is physically or emotionally weaker to do something (or refrain from doing something) in order to avoid retribution. Telling a coworker that he or she will "be sorry" for carrying out a particular action is a clear example of intimidation.
Page Ref: 2653
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.9. Explain how authority gradients influence teamwork and patient safety. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Choose communication styles that diminish the risks associated with authority gradients among team members to accomplish care, assert one's own views, and minimize risks associated with handoffs among providers and across transitions in care. | Nursing Process: Implementation
Learning Outcome: 40.3. Analyze the components of unprofessional behaviors.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

8) A new nurse is concerned about beginning a new position as a staff nurse. Which process should the new nurse understand that involves the acquisition of lifelong learning, experience, technical expertise, and interdependent collaboration required to become a professional nurse?
A) Maturation
B) Formation
C) Transformation
D) Socialization
Answer: B
Explanation: A) The acquisition of learning experiences and expertise is not maturation.
B) Formation is an evolutionary process that requires the acquisition of lifelong learning, experience, technical expertise, and interdependent professional collaboration.
C) The acquisition of learning experiences and expertise is not transformation.
D) The acquisition of learning experiences and expertise is not socialization.
Page Ref: 2649
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the health care team. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Demonstrate self-awareness, self-care, self-growth; Be open and nonjudgmental. | Nursing Process: Implementation
Learning Outcome: 40.1. Analyze the components of professionalism within the practice of nursing.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

Exemplar 40.A   Commitment to Profession

1) Which action by the novice nurse demonstrates commitment to a new job on a busy cardiac care unit?
A) Joining the American Nurses Association (ANA)
B) Questioning the preceptor during all procedures
C) Arriving at every shift on time
D) Exhibiting clinical competence
Answer: C
Explanation: A) Joining the ANA is a commitment, but it is not relevant to this question.
B) It should not be necessary for the new nurse to question every procedure, given that the new nurse has some prior clinical experience.
C) The new nurse can demonstrate commitment by showing up for all shifts in a timely fashion.
D) Clinical competence develops over time, and the new nurse is not likely to exhibit complete competence yet.
Page Ref: 2655
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the healthcare team. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Assessment
Learning Outcome: 40.A. Analyze commitment to profession as it relates to professionalism. Describe factors associated with professional commitment
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

2) A novice nurse is caring for an older adult client with dementia. The nurse leaves for a break and forgets to put the call light within the client's reach. When checking on the nurse's clients, a colleague discovers the nurse's negligence. Which conclusion by the colleague is appropriate?
A) The novice nurse is appropriately taking care of self.
B) The novice nurse's workload is too difficult.
C) The novice nurse is demonstrating inappropriate safety measures for the client.
D) The novice nurse is demonstrating appropriate comfort measures for the client.
Answer: C
Explanation: A) It is appropriate for nurses to take breaks; however, client safety should be the nurse's first commitment.
B) There is no evidence that the nurse's workload is too difficult.
C) The novice nurse is demonstrating inappropriate safety measures by not leaving the call light within the client's reach.
D) The scenario does not provide any information about comfort measures.
Page Ref: 2655
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the healthcare team. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Assessment
Learning Outcome: 40.A. Analyze commitment to profession as it relates to professionalism. Describe factors associated with professional commitment.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

3) Which action by a student nurse is most consistent with commitment to the nursing profession?
A) The student calls in sick for clinicals in order to study for a class exam.
B) The student declines to observe a new procedure for giving a necessary bath.
C) The student misses class to attend a political rally.
D) The student calls in sick for clinicals because of a respiratory infection.
Answer: D
Explanation: A) Studying for a class exam is important, but not more important than learning clinical skills.
B) A student who demonstrates commitment seeks out as many new learning experiences as possible.
C) Attending a political rally may be important, but for the student, attending class demonstrates greater commitment to the profession of nursing.
D) Whereas calling in sick for a frivolous reason demonstrates a lack of commitment, calling in sick with a bona fide illness demonstrates protection of clients who are already compromised.
Page Ref: 2655
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: II.C.1. Acknowledge own potential to contribute to effective team functioning. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Assessment
Learning Outcome: 40.A. Analyze commitment to profession as it relates to professionalism. Describe types of commitment.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

4) A new nurse decides to join a professional organization that represents the practice specialty. Which type of commitment does this action exemplify?
A) Affective
B) Normative
C) Subjective
D) Continuance
Answer: A
Explanation: A) Affective commitment is an attachment to a profession and includes identification with, and involvement in, the profession. This type of commitment develops when involvement in a profession produces a satisfying experience.
B) Normative commitment is a feeling of obligation to continue in the profession.
C) Subjective is not a type of commitment.
D) Continuance commitment is awareness of the costs associated with leaving the profession.
Page Ref: 2655
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.1. Describe own strengths, limitations, and values in functioning as a member of a team. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Assessment
Learning Outcome: 40.A. Analyze commitment to profession as it relates to professionalism. Describe types of commitment.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

5) Which behaviors by a new nurse are likely to reduce stress and burnout? **Select all that apply.**
A) Meditate or take a long soak in a tub.
B) Join a local aerobics class.
C) Participate in a professional organization.
D) Refuse to acknowledge personal limitations.
E) Don't accept failure; try, try, and try again.
Answer: A, B, C
Explanation: A) Nurses can prevent burnout by using healthy techniques to manage stress including meditating or taking a long soak in a tub.
B) Nurses can prevent burnout by using healthy techniques to manage stress such as exercise.
C) Nurses can prevent burnout by participating in professional organizations.
D) Refusing to acknowledge personal limitations will not prevent burnout.
E) Refusing to accept failure will not prevent burnout.
Page Ref: 2656
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: V.C.2. Appreciate the cognitive and physical limits of human performance. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Implementation
Learning Outcome: 40.A. Analyze commitment to profession as it relates to professionalism. Discuss ways to manage stress associated with commitment to a profession.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

6) A nurse is always on time, neat in appearance, and caring toward clients. Which statement best characterizes this nurse's level of professional commitment?
A) The nurse is demonstrating a pattern of behaviors congruent with nursing's professional code of ethics.
B) The nurse is demonstrating a strong belief in, and acceptance of, the unit's goals, values, and morals.
C) The nurse is demonstrating a willingness to exert control over personal behaviors.
D) The nurse is demonstrating a strong desire to be part of a group.
Answer: A
Explanation: A) Factors associated with professional commitment include a strong belief in, and acceptance of, the profession's code, role, goals, values, and morals; a willingness to exert considerable personal effort on behalf of the profession; a strong desire to maintain membership in the profession; and a pattern of behaviors congruent with the nurses' professional code of ethics.
B) The nurse's behavior is not demonstrating a strong belief in, and acceptance of, the unit's goals, values, and morals.
C) The nurse's behavior is not demonstrating a willingness to exert control over personal behaviors.
D) The nurse's behavior is not demonstrating a strong desire to be part of a group.
Page Ref: 2655
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.C.1. Acknowledge own potential to contribute to effective team functioning. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Assessment
Learning Outcome: 40.A. Analyze commitment to profession as it relates to professionalism. Describe factors associated with professional commitment.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

7) A student nurse says, "I'm nervous about taking the NCLEX, and I'm a little worried about all the responsibility that comes with being a registered nurse. At the same time, I'm eager to pass the test so I can start working. I think the rewards of nursing are well worth the hard work and sacrifice." This statement suggests that the student nurse is in which stage of commitment?
A) The integrated stage
B) The testing stage
C) The passionate stage
D) The exploratory stage
Answer: A
Explanation: A) The integrated stage is the final stage of commitment development. Individuals who reach this stage have integrated both positive and negative elements of the profession into a more flexible, complex, and enduring form of commitment. They act out their commitment as a matter of habit. These students are in the final stages of their nursing program and are beginning to see themselves as nurses, eager to take the NCLEX-RN and begin employment.
B) The second stage is the testing stage, during which individuals discover negative elements of the profession.
C) The third stage is the passionate stage of commitment, which begins as the individual synthesizes the positive and negative elements from the first two stages.
D) The first stage is the exploratory stage, in which individuals explore the positive aspects of the profession.
Page Ref: 2656
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.C.1. Acknowledge own potential to contribute to effective team functioning. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Assessment
Learning Outcome: 40.A. Analyze commitment to profession as it relates to professionalism. Outline the stages of the commitment process.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

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8) Which type of commitment involves a feeling of obligation to continue in a profession, usually as a result of having received benefits or having had positive experiences through engagement in the profession?
A) Continuance commitment
B) Affective commitment
C) Reciprocal commitment
D) Normative commitment
Answer: D
Explanation: A) Continuance commitment is awareness of the costs associated with leaving a profession; it develops when negative consequences of leaving, such as loss of income, are seen as reasons to remain.
B) Affective commitment is an attachment to a profession and includes identification with, and involvement in, the profession.
C) Reciprocal is not a type of commitment.
D) Normative commitment is a feeling of obligation to continue in a profession that develops as a result of having received benefits or having had positive experiences through engagement in that profession.
Page Ref: 2656
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.1. Describe own strengths, limitations, and values in functioning as a member of a team. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Assessment
Learning Outcome: 40.A. Analyze commitment to profession as it relates to professionalism. Describe types of commitment.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

9) During which stage of commitment do nursing students tend to focus on the negative elements of nursing and weigh their ability to handle those elements?
A) Passionate stage
B) Testing stage
C) Exploratory stage
D) Quiet-and-bored stage
Answer: B
Explanation: A) The third stage is the passionate stage of commitment, which begins as the individual synthesizes the positive and negative elements from the first two stages.
B) The testing stage is the period in which individuals discover negative elements of the profession. During this stage, individuals start to assess their willingness and ability to deal with those negative elements.
C) The first stage is the exploratory stage, in which individuals explore the positive aspects of the profession.
D) The fourth stage is the quiet-and-bored stage of commitment, in which students settle into the humdrum routines of the nursing program.
Page Ref: 2656
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.C.1. Acknowledge own potential to contribute to effective team functioning. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Assessment

Learning Outcome: 40.A. Analyze commitment to profession as it relates to professionalism. Describe types of commitment.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

Exemplar 40.B Professional Development

1) Which individual is widely considered to be the founder of public health nursing?
A) Lavinia Dock
B) Lillian Wald
C) Mary Mahoney
D) Linda Richards
Answer: B
Explanation: A) Lavinia Dock is best known for championing legislation to make nursing an autonomous profession.
B) Lillian Wald is widely considered to be the founder of public health nursing because of her work providing nursing, social, and educational services to poor residents in the slums of New York City.
C) Mary Mahoney was the first African American professional nurse.
D) Linda Richards was America's first trained nurse; the practices of nurse's notes, doctor's orders, and nurses wearing uniforms all originated with her.
Page Ref: 2658
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Assessment

Learning Outcome: 40.B. Analyze professional development as it relates to accountability. List nursing leaders who made notable contributions to the profession.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

2) The nurse is administering a bed bath to a client in a long-term care facility. The nurse is careful to cover the client during the bath. Which nursing role does this action reflect?
A) Communicator
B) Caregiver
C) Client advocate
D) Teacher
Answer: B
Explanation: A) As a communicator, the nurse identifies client problems, then communicates these verbally or in writing to other members of the health team.
B) The caregiver role includes those activities that assist the client physically and psychologically while preserving the client's dignity. In this scenario, the nurse is acting in the role of a caregiver.
C) As a client advocate, the nurse acts to protect clients and represents their needs and wishes to other health professionals.
D) As a teacher, the nurse helps clients learn about their health and the healthcare procedures they need to perform, to maintain, or restore their health.
Page Ref: 2661
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Assessment

Learning Outcome: 40.B. Analyze professional development as it relates to accountability. Differentiate the components of contemporary nursing practice.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

3) The charge nurse observes that a fellow charge nurse on the unit seems impaired and unable to perform client care. Which action by the charge nurse is most appropriate in this situation?
A) Notifying security
B) Calling the unit's nurse manager
C) Discussing the situation with the nursing supervisor
D) Confronting the other nurse directly
Answer: C
Explanation: A) Security may need to be notified eventually, but again, that decision would be made by the nursing supervisor.
B) Although the nurse manager will need to be notified, the charge nurse must first notify the nursing supervisor so he or she can determine how to proceed.
C) Discussing the situation with the nursing supervisor is the appropriate decision because the supervisor is the next highest link in the chain of command. As such, the supervisor is responsible for making the appropriate decision about how to deal with the potentially impaired charge nurse.
D) Confronting the other nurse would not be appropriate given that the nurse seems impaired.
Page Ref: 2660
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: II.B.7. Clarify roles and accountabilities under conditions of potential overlap in team member functioning. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Implementation
Learning Outcome: 40.B. Analyze professional development as it relates to accountability. Differentiate the components of contemporary nursing practice.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

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4) A nurse is overseeing a group of students who are completing a clinical rotation on a medical-surgical unit. The students are providing direct client care with the assistance of the nurse. The nurse who is overseeing the students is functioning in which capacity?

A) Clinical nurse specialist

B) Nurse practitioner

C) Nurse entrepreneur

D) Nurse educator

Answer: D

Explanation: A) A clinical nurse specialist has an advanced degree or expertise and is considered to be an expert in a specialized area of practice. The nurse provides direct client care, educates others, consults, conducts research, and manages care.

B) A nurse practitioner has an advanced education, is a graduate of a nurse practitioner program, and usually deals with nonemergency acute or chronic illness and provides primary ambulatory care.

C) A nurse entrepreneur usually has an advanced degree, manages a health-related business, and may be involved in education, consultation, or research.

D) Nurse educators are responsible for classroom and often clinical teaching.

Page Ref: 2661

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Implementation

Learning Outcome: 40.B. Analyze professional development as it relates to accountability. Differentiate expanded careers for nurses.

MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

5) A student nurse is trying to explain nursing to family members. Which contemporary aspects of nursing might the student nurse include in the explanation? **Select all that apply.**

A) Nursing is a science.
B) Nursing is easy.
C) Nursing is a new profession.
D) Nursing is focused on illness.
E) Nursing is holistic.

Answer: A, E

Explanation: A) The American Nurses Association (ANA) recognizes the influence and contribution of the science of caring on nursing philosophy and practice.
B) Nursing is not identified as easy.
C) Nursing is not a new profession.
D) The nurse is concerned with both healthy and ill individuals.
E) The nurse approaches care holistically, considering its physical, cognitive, psychological, and spiritual elements.

Page Ref: 2659

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Implementation

Learning Outcome: 40.B. Analyze professional development as it relates to accountability. Differentiate the components of contemporary nursing practice.

MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

6) A client who has been diagnosed with terminal pancreatic cancer states to the nurse, "I do not want any further treatment, but I am afraid my doctor will insist that I continue chemotherapy." Which role is the nurse performing when informing the healthcare provider of the client's choice to stop treatment?

A) Change agent
B) Case manager
C) Advocate
D) Teacher

Answer: C

Explanation: A) As change agents, nurses assist clients to make modifications in their behavior.
B) Nurse case managers work with the multidisciplinary healthcare team to measure the effectiveness of the case management plan and monitor outcomes.
C) The nurse is acting as client advocate, because this role involves representing the client's needs and wishes to other health professionals.
D) As teachers, nurses help clients learn about their health and about healthcare procedures used to restore or maintain their health.

Page Ref: 2661
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Implementation

Learning Outcome: 40.B. Analyze professional development as it relates to accountability. Differentiate the components of contemporary nursing practice.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

7) A nurse working in the emergency department (ED) notes that a healthcare provider smells strongly of alcohol and appears confused. Which action by the nurse is appropriate?
A) Contact the charge nurse to report the problem.
B) Tell the healthcare provider to seek alcohol rehabilitation.
C) Report the healthcare provider to the hospital CEO.
D) Report the healthcare provider to the state licensing board.
Answer: A
Explanation: A) In a hospital, problems like this one are usually first reported to the charge nurse, then to the unit manager.
B) Making suggestions to the healthcare provider about rehabilitation does not address the nurse's responsibility to clients and the organization.
C) The nurse should address the problem through the chain of command within the hospital.
D) The nurse should address the problem through the chain of command within the hospital.
Page Ref: 2660
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: II.B.7. Clarify roles and accountabilities under conditions of potential overlap in team member functioning. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Implementation
Learning Outcome: 40.B. Analyze professional development as it relates to accountability. Differentiate the components of contemporary nursing practice.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

8) A nurse obtains certification to provide direct client care, educate others, consult, conduct research, and manage oncology care. Which expanded nursing role best describes this nurse's career position?
A) Nurse anesthetist
B) Clinical nurse specialist
C) Nurse educator
D) Nurse researcher
Answer: B
Explanation: A) Nurse anesthetists have completed advanced education in an accredited program in anesthesiology.
B) This nurse is acting in the role of clinical nurse specialist. A clinical nurse specialist has an advanced degree or expertise in a specialized area of practice; has passed a certification exam and obtained any other required credentialing; and works to provide direct client care, educate others, consult, conduct research, and manage care.
C) Nurse educators are employed in nursing programs, at educational institutions, or in hospital staff education and may have a baccalaureate degree or more advanced preparation.
D) Nurse researchers usually have advanced education at the doctoral level.
Page Ref: 2662
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Assessment
Learning Outcome: 40.B. Analyze professional development as it relates to accountability. Differentiate expanded careers for nurses.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

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9) A staff nurse serves as a valuable source of expertise and advice to other nurses on the unit. However, the nurse does not have the authority to direct their work. Which characteristic does this nurse have?

A) Staff authority
B) Responsibility
C) Line authority
D) Organizational authority

Answer: A

Explanation: A) This nurse possesses staff authority, or the power to provide advice and support to employees or departments but not to assign tasks.

B) Responsibility means being accountable for meeting personal or organizational objectives and performing required tasks.

C) Line authority is the power to direct the activities of subordinates within an organization.

D) Organizational authority is not a term used to describe this type of situation.

Page Ref: 2660

Cognitive Level: Understanding

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Assessment

Learning Outcome: 40.B. Analyze professional development as it relates to accountability. Differentiate the components of contemporary nursing practice.

MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

Exemplar 40.C Work Ethic

1) After accidentally providing food to a client who is NPO for surgery, the nurse reports the error to the healthcare provider and follows hospital policy for managing the error. Which characteristic is demonstrated by the actions of this nurse?

A) Social justice

B) Human dignity

C) Reliability

D) Accountability

Answer: D

Explanation: A) Social justice involves upholding moral, legal, and humanistic principles.

B) Human dignity involves respect for the worth and uniqueness of individuals and populations.

C) Reliability implies that a nurse is dependable.

D) Accountability involves accepting responsibility for the consequences of one's actions, as the nurse did in this scenario by informing the provider and following hospital policy for managing the error.

Page Ref: 2664

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: II.B.3. Act with integrity, consistency, and respect for differing views. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; Collaborate and work cooperatively with others. | Nursing Process: Implementation

Learning Outcome: 40.C. Analyze work ethic as it relates to professionalism. Outline the importance of reliability and accountability for the professional nurse.

MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

2) During a staff meeting, the new nurse manager informs the staff that each nurse will be getting an email account that needs to be checked daily for information from the manager. Which responses to this policy would be expected of a "Generation X" nurse? **Select all that apply.**
A) "Can we access the email account from home?"
B) "That sounds like a great idea."
C) "I would rather get the information directly from you."
D) "I would rather receive the information in a unit newsletter."
E) "Can we use this account to email one another?"
Answer: A, B, E
Explanation: A) Given their high level of comfort with technology, nurses in these age groups would also likely ask whether the new email accounts could be accessed from home.
B) Both Generation X and Generation Y/Millennial nurses would likely support the new email policy.
C) Older nurses would likely prefer communication that is not attached to technology.
D) Older nurses would likely prefer communication that is personal.
E) Given their high level of comfort with technology, nurses in these age groups would also likely ask whether the new email accounts could be used to communicate with other staff members.
Page Ref: 2666
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.C.5. Respect the unique attributes that members bring to a team, including variations in professional orientations and accountabilities. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; Collaborate and work cooperatively with others. | Nursing Process: Assessment

Learning Outcome: 40.C. Analyze work ethic as it relates to professionalism. Summarize generational differences in work ethic.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

3) A charge nurse is making assignments for the shift and notes that a client from a different culture was recently admitted and will require a thorough admission assessment during the upcoming shift. Which generation of nurse is likely to be the most culturally sensitive and thus the best choice for this client assignment?
A) The Millennial nurse
B) The Generation X nurse
C) The veteran nurse
D) The baby boomer nurse
Answer: A
Explanation: A) A nurse from the Millennial generation would most likely exhibit the highest level of cultural sensitivity and would thus be the best choice for this assignment. Millennial generation nurses have received the most education regarding culturally sensitive care and can be a good resource for the older nurses on the unit.
B) Generation X nurses would not have the greatest amount of cultural sensitivity knowledge.
C) The veteran nurse would not have the greatest amount of cultural sensitivity knowledge.
D) The baby boomer nurse would not have the highest level of cultural sensitivity knowledge.
Page Ref: 2666
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.C.5. Respect the unique attributes that members bring to a team, including variations in professional orientations and accountabilities. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; Collaborate and work cooperatively with others. | Nursing Process: Assessment

Learning Outcome: 40.C. Analyze work ethic as it relates to professionalism. Summarize generational differences in work ethic.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

4) A nurse is reprimanded for being habitually late. Which action by the nurse would best address this performance issue?
A) The nurse must take responsibility and accept any corrective action.
B) The nurse must provide proof that all instances of tardiness were unavoidable.
C) The nurse must have a positive attitude.
D) The nurse must trade shifts in order to be on time.
Answer: A
Explanation: A) Reliability and accountability are key factors in professionalism. From a systems perspective, each nurse is responsible for completing the duties of the job appropriately so that others can complete their work, too.
B) Providing proof for being tardy would not address this issue.
C) Having a positive attitude would not address this issue.
D) Trading shifts would not address this issue.
Page Ref: 2664
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.B.3. Act with integrity, consistency, and respect for differing views. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; Collaborate and work cooperatively with others. | Nursing Process: Implementation
Learning Outcome: 40.C. Analyze the work ethic as it relates to professionalism. Outline the importance of reliability and accountability for the professional nurse.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

5) The nurse failed to complete a competency within the required time frame. When confronted by the manager, the nurse says, "Oh well, it's not like I don't know what I'm doing." This nurse's statement is most reflective of which quality?
A) Arrogance, which prevents the nurse from developing an accurate assessment of personal strengths and weaknesses
B) Pessimism, which endangers the nurse's professionalism
C) Optimism, which helps the nurse realize that things will turn out for the best
D) Sarcasm, which threatens the nurse's job performance
Answer: A
Explanation: A) Arrogance, or excessive pride and a feeling of superiority, can be an extremely dangerous characteristic in the nurse, as it can lead to a false belief that the nurse is always right and does not need input from others.
B) Pessimism is the belief that the current situation is always bad and may become worse.
C) Optimism is a feeling that things will turn out for the best.
D) Sarcasm is a negative attitude; however, this does not describe the statement the nurse made.
Page Ref: 2664
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.1. Describe own strengths, limitations, and values in functioning as a member of a team. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; Collaborate and work cooperatively with others. | Nursing Process: Assessment
Learning Outcome: 40.C. Analyze work ethic as it relates to professionalism. Describe the influence of attitude and enthusiasm on the work environment.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

6) The charge nurse, who is a member of Generation X, is training a new nurse, who is a member of the Millennial generation. Which aspects of the two nurses' work ethics may be in conflict? **Select all that apply.**
A) Preference for self-directed activity versus a need for feedback
B) Loyalty to profession versus desire for new challenges and opportunities
C) Workaholic orientation versus need for work-life balance
D) Respect for authority versus questioning of authority
E) Preference for personal forms of communication versus preference for communication via cell phone
Answer: A, B
Explanation: A) Nurses from Generation X tend to seek challenges and are self-directed.
B) Nurses from Generation X desire employment in which they can balance work and personal life.
C) Nurses from the baby boomer generation have a workaholic orientation.
D) Neither Generation X nor millennials respect authority and will question it.
E) Baby boomer nurses prefer personal forms of communication.
Page Ref: 2666
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.C.5. Respect the unique attributes that members bring to a team, including variations in professional orientations and accountabilities. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; Collaborate and work cooperatively with others. | Nursing Process: Assessment

Learning Outcome: 40.C. Analyze work ethic as it relates to professionalism. Summarize generational differences in work ethic.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

7) In which way would a healthcare facility's management best take advantage of the multigenerational nursing staff?
A) Emphasizing the unique strengths each generation brings to the workplace
B) Encouraging the hardworking, loyal veterans to serve as mentors for the younger nurses
C) Highlighting the adaptability of the techno-savvy Generation X nurses
D) Encouraging the older nurses to adopt the optimistic viewpoint of the Millennial nurses
Answer: A
Explanation: A) Celebrating the unique strengths of each generation of nurse can decrease interpersonal tension and facilitate personal growth. Nurses who learn to acknowledge and appreciate their colleagues from different backgrounds, including generational backgrounds, have a distinct advantage.
B) Encouraging veterans to mentor younger nurses is not the best way to take advantage of the multigenerational nursing staff.
C) Highlighting technological savvy generation X nurses is not the best way to take advantage of the multigenerational nursing staff.
D) Encouraging veterans to adopt the outlook of Millennials is not the best way to take advantage of the multigenerational nursing staff.
Page Ref: 2665
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.C.5. Respect the unique attributes that members bring to a team, including variations in professional orientations and accountabilities. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; Collaborate and work cooperatively with others. | Nursing Process: Planning
Learning Outcome: 40.C. Analyze work ethic as it relates to professionalism. Summarize generational differences in work ethic.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

8) Which description reflects a nurse's work ethic?
A) Belief in the importance and moral worth of work
B) Desire to advance in a chosen profession
C) Level of affective commitment to a profession
D) Degree of optimism with regard to the work environment
Answer: A
Explanation: A) A person's work ethic reflects their belief in the importance and moral worth of work.
B) An individual does not need to be part of a specific profession in order to have a strong work ethic.
C) An individual does not need to be part of a specific profession in order to have a strong work ethic.
D) Although an optimistic attitude is often associated with a strong work ethic, optimism itself does not determine an individual's work ethic.
Page Ref: 2663
Cognitive Level: Remembering
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: II.A.1. Describe own strengths, limitations, and values in functioning as a member of a team. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; Collaborate and work cooperatively with others. | Nursing Process: Assessment
Learning Outcome: 40.C. Analyze the work ethic as it relates to professionalism. Describe the influence of attitude and enthusiasm on the work environment.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

9) Which situation would be considered an example of insubordination?
A) A staff nurse informs the unit supervisor that she can't complete an assigned care task because it is outside her scope of practice.
B) A staff nurse informs the unit supervisor that he cannot complete an assigned care task because it requires a piece of equipment that is not currently available.
C) A staff nurse informs the unit supervisor that she won't complete an assigned care task because it's beneath her level and more appropriate for unlicensed assistive personnel.
D) A staff nurse informs the unit supervisor that he cannot complete an assigned care task because another nurse has already performed the task.
Answer: C
Explanation: A) Professional nurses should refuse work assignments only when they are not qualified or not prepared to perform the assignment–as would be the case when a task is outside the nurse's scope of practice.
B) Professional nurses should refuse work assignments only when they are not qualified or not prepared to perform the assignment–as would be the case when a needed piece of equipment is unavailable.
C) The nurse who refuses a task simply because she feels it is "beneath her level" would be engaging in insubordinate behavior.
D) Professional nurses should refuse work assignments only when they are not qualified or not prepared to perform the assignment. Refusal to perform a task would also be appropriate if completing the task would result in duplication of services.
Page Ref: 2657
Cognitive Level: Understanding
Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: II.A.1. Describe own strengths, limitations, and values in functioning as a member of a team. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; Collaborate and work cooperatively with others. | Nursing Process: Assessment
Learning Outcome: 40.C. Analyze the work ethic as it relates to professionalism. Outline the importance of reliability and accountability for the professional nurse.
MNL LO: Analyze the concept of professional behaviors and its application to nursing care.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 41 Teaching and Learning

The Concept of Teaching and Learning

1) The nurse is preparing to discharge a client who experienced a myocardial infarction. The client will have to make many lifestyle changes, and the nurse is providing instruction on how to implement a heart-healthy lifestyle. Which concept related to teaching and learning is the nurse focusing on with this client?
A) Safety
B) Development
C) Communication
D) Health, Wellness, Illness, and Injury
Answer: D
Explanation: A) Safety is the knowledge of safe practices to help avoid accidents and injuries.
B) Development focuses on learning abilities, sensory and motor function, and cognitive functioning.
C) Communication focuses on the use of verbal, nonverbal, and written methods to convey information.
D) Health, wellness, illness, and injury empowers individuals to make lifestyle choices that promote health and prevent illness and injury.
Page Ref: 2671
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: III.C.5. Value the need for continuous improvement in clinical practice based on new knowledge. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Implementation
Learning Outcome: 41.1. Analyze the nurse's role in teaching and learning.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

2) The nurse is caring for an adult client who has been diagnosed with high cholesterol. Which information is important for the nurse to consider when teaching this adult client?
A) Adults are more oriented to learning when the material is useful immediately.
B) Adults are more likely to adhere to a regimen than are children.
C) Adults usually can find information on their own.
D) Adults do not need to be evaluated for understanding as children do.
Answer: A
Explanation: A) When teaching a client, the nurse considers that most people learn and retain information if the information is immediately useful.
B) Adults will not necessarily adhere to a regimen more than children will.
C) Some clients can find information on their own; however, not all information that the client can find is factual, and clients should be taught how to discern the difference between trustworthy information and unreliable and potentially dangerous information.
D) All clients need to be evaluated to ensure that the right information was retained.
Page Ref: 2678
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.C.5. Value the need for continuous improvement in clinical practice based on new knowledge. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Learning: Learn continuously, learn cooperatively. | Nursing Process: Planning
Learning Outcome: 41.5. Differentiate considerations related to teaching and learning throughout the lifespan.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

3) Which theory of learning holds that knowledge acquisition is the ongoing assimilation and accommodation of new experiences and interpretations?

A) Constructivist
B) Behaviorist
C) Social learning
D) Cognitive

Answer: A

Explanation: A) Constructivist theory holds that knowledge acquisition is the ongoing assimilation and accommodation of new experiences and interpretations.

B) In behaviorist theory, learning is thought to occur when an individual's response to a stimulus is either positively or negatively reinforced.

C) In social learning theory, learning primarily results from instruction and observation.

D) In cognitive learning theory, learning involves the processes of acquiring, processing, and using new information.

Page Ref: 2673

Cognitive Level: Remembering

Client Need/Sub: Health Promotion and Maintenance

Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Assessment

Learning Outcome: 41.2. Outline the relationship between teaching and learning and other concepts.

MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

4) The nurse in a neonatal intensive care unit (NICU) wants to teach a mother of a premature baby how to give her baby a bath. Which statement by the mother reflects a readiness to learn?
A) "You'll give us written instructions before we go home, correct?"
B) "When my baby is just a little bigger, I'll feel more comfortable giving him a bath."
C) "I want to make sure my husband is here, in case I don't hear everything that's said."
D) "I'm so afraid I'll hurt my baby with all these tubes and wires."
Answer: C
Explanation: A) Statements about fear of the situation need to be addressed so that the fear will not inhibit the learning process.
B) Wanting to wait until the baby is older reflects uncertainty and possibly fear and should be addressed before learning can occur.
C) Readiness to learn is the demonstration of behaviors or cues that reflect a learner's motivation, desire, and ability to learn at a specific time. The client who wants her husband involved is demonstrating motivation and willingness to learn.
D) Statements about fear of the situation need to be addressed so that the fear will not inhibit the learning process.
Page Ref: 2674
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: IV.A.1. Describe strategies for learning about the outcomes of care in the setting in which one is engaged in clinical practice. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Evaluation
Learning Outcome: 41.4. Analyze aspects of learning.

MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

5) A nursing student has been assigned to present a teaching project to the class, using each of Bloom's taxonomy domains. The student has planned several activities to include when presenting the project to the class. Which activities are within the affective domain? **Select all that apply.**
A) Class members must read a paragraph about a new clinical trial, summarize the information, and present it to the rest of the class.
B) Class members must list the technical skills they have learned.
C) Class members must demonstrate a favorite nursing skill for the class.
D) Class members must reflect on how they felt the first time they provided direct client care.
E) Class members must identify two attitudinal changes that have occurred in their lives since beginning their nursing education.
Answer: D, E
Explanation: A) Summarizing information is part of the cognitive domain.
B) Listing technical skills is part of the cognitive domain, which includes knowing, comprehending, application, analysis, synthesis, and evaluation.
C) The psychomotor domain is the "skill" domain and includes hands-on motor skills, such as demonstration.
D) The affective domain includes emotional responses to tasks, such as feelings, emotions, interests, attitudes, and appreciations.
E) The affective domain includes emotional responses to tasks, such as feelings, emotions, interests, attitudes, and appreciations.
Page Ref: 2688
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: IV.A.1. Describe strategies for learning about the outcomes of care in the setting in which one is engaged in clinical practice. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Planning
Learning Outcome: 41.2. Outline the relationship between teaching and learning and other concepts.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

6) The nurse is caring for a group of clients who are recovering in a rehabilitation hospital following total hip replacements. Which client is exhibiting the highest motivation to learn?
A) A client who has been there the longest and is a great "coach" for newcomers
B) A client who has been struggling with following nursing directives regarding discharge goals
C) A client who is excited to learn ambulation techniques
D) The client who has just moved in and is already eager for discharge
Answer: C
Explanation: A) Motivation must be experienced by the client, not by someone else (as in being a "coach" for newcomers).
B) Clients who struggle with rules or following prescribed courses of treatment are not motivated to learn the best reason for their particular plan of action; they may be "bucking" the system.
C) The client who is excited to learn about ambulation techniques understands that learning about it will help take his recovery to a high level.
D) The client who is already waiting to go home may be eager for that to occur, but not necessarily to the extent of being ready to learn how to achieve this end.
Page Ref: 2674
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV.A.1. Describe strategies for learning about the outcomes of care in the setting in which one is engaged in clinical practice. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Assessment
Learning Outcome: 41.4. Analyze aspects of learning.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

7) The nurse educator is preparing to teach a group of nursing students how to navigate the internet to research healthcare information. Which information does the educator plan to include during lecture?
A) A directory of campus internet sites of interest
B) How to search for and evaluate health information
C) A directory of libraries
D) Information technology instruction
Answer: B
Explanation: A) Sites of interest for the campus would not directly impact the nursing program.
B) Campus health centers that use the internet as a tool for health education must train nursing students regarding how to search for and evaluate the health information they find.
C) Libraries are important but knowing about them would not be a part of this presentation.
D) Information technology is a subject that teaches nurses how to use technology for the delivery of care and communication.
Page Ref: 2679
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.1. Appreciate the necessity for all health professionals to seek lifelong, continuous learning of information technology skills. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Retrieve research findings and other sources of information. | Nursing Process: Planning
Learning Outcome: 41.6. Analyze the impact of the internet on teaching and learning.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

8) The nurse provides medication teaching for a client who will be going home on new medications. Which statement by the client best illustrates compliance with the medication plan?
A) "I think you should have waited until I was ready to go home. Maybe I'd remember better."
B) "I'm glad to know about my new medications. It makes taking them all a lot easier."
C) "If I take my medications as prescribed, I'll feel better."
D) "I already knew most of what you told me."
Answer: B
Explanation: A) Learning about the medications helps the client understand why they are prescribed and improves the possibility for following the prescribed regimen.
B) Compliance is best illustrated when the individual recognizes and accepts the need to learn, then follows through with appropriate behaviors that reflect learning.
C) A statement that restates the advice of the healthcare provider does not lead to compliance.
D) Statements of prior knowledge do not necessarily lead to compliance.
Page Ref: 2672
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Evaluation
Learning Outcome: 41.2. Outline the relationship between teaching and learning and other concepts.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

9) The nurse has a 7-year-old client recovering from partial-thickness burns to the arms and hands. This client has shown sensitivity to loud noises and bright lights, and at times will only pay attention to parents if overstimulated. Which environment would the nurse use to teach this client?
A) Client's room
B) Pediatric ward waiting area
C) Hospital cafeteria
D) Pediatric ward play area
Answer: A
Explanation: A) The client's room, where the nurse can control to a greater degree the amount of light and noise, is best for teaching this client.
B) The waiting area for the pediatric ward would be too busy.
C) The cafeteria is likely to be too loud and bright.
D) The play area would be too busy for teaching this client.
Page Ref: 2676
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Planning
Learning Outcome: 41.5. Differentiate considerations related to teaching and learning throughout the lifespan.

MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

Exemplar 41.A Patient/Consumer Education

1) A client who had outpatient surgery is given an instruction sheet in preparation for discharge. When the nurse asks if the instructions are clear, the client says, "I'll read them later when I have my glasses; besides, you told me everything I need to know." Based on these statements, what would the nurse suspect?
A) The client may be unable to read the instructions.
B) The client already knows the information.
C) The client does not want the written information.
D) The client is ready to learn.
Answer: A
Explanation: A) The client who refuses to read instructions may not be able to read. The nurse should assess the client's ability to read to ensure proper treatment and to evaluate the client's understanding of the information.
B) There is no evidence that the client already knows the information.
C) It is unlikely that the client does not want the information. The client said that he'd read the instructions later, and so is not opposed to written information.
D) The client may be ready to learn, but the client's inability to read may be masking that fact.
Page Ref: 2685
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Assessment
Learning Outcome: 41.A. Analyze patient/consumer education as it relates to teaching and learning. Summarize the aspects of identifying learning needs.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

2) The home health nurse is working with a client who has chronic obstructive pulmonary disease. Which problem will take the highest priority for implementing client education?
A) Altered gas exchange
B) Changed breathing pattern
C) Anxiety
D) Inability to perform activities
Answer: A
Explanation: A) The priority for the nurse to address is altered gas exchange. If the client's oxygen level is too low, or the carbon dioxide level is too high, the client's life may be threatened.
B) There is no evidence that the client's breathing pattern is changed.
C) Anxiety might occur; however, this would not be the priority.
D) The client might have issues performing activities; however, this is not the priority.
Page Ref: 2687
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Diagnosis
Learning Outcome: 41.A. Analyze patient consumer education as it relates to teaching and learning. Outline the steps of developing a teaching plan.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

3) The nursing student is planning an educational program for a school project. The program is focusing on cancer detection education for a community group. Which approach should the nursing student include to address the various learning styles of the target group?
A) A lecture using many examples for each learning need
B) Multicolored brochures with bright colors
C) A game board with client matching terms
D) Audiovisuals, examples, group discussions, and activities
Answer: D
Explanation: A) Lecture may not meet the needs of the entire group.
B) Multicolored brochures would only address those learners who learn in the visual mode.
C) Games are a useful teaching tool but not necessarily useful when addressing a large group of individuals with varying learning styles.
D) When teaching a group, use strategies to address visual, auditory, manipulative, group, and problem-solving types of learners. Using different techniques and a variety of activities is a good way to match the various learning styles of group participants.
Page Ref: 2689
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Planning
Learning Outcome: 41.A. Analyze patient/consumer education as it relates to teaching and learning. Outline the steps of developing a teaching plan.

MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

4) A client with a new permanent colostomy is being discharged. Which action should the nurse take when organizing the teaching experience?
A) Ask the client to say what is already known about colostomy care.
B) Make sure the client's spouse is present before the teaching session begins.
C) Start from the beginning and proceed through all steps required to perform colostomy care.
D) Break the information into small sessions to enhance learning.
Answer: A
Explanation: A) The nurse should find out what the client knows, and then proceed to the unknown. This gives the client confidence. This information can be elicited either by asking questions or by having the client take a pretest or fill out a form.
B) Having the spouse present is always a good idea but finding out what the client already knows is more important when organizing teaching.
C) Going over information already learned is not practicing good time management for the nurse or the client.
D) Unless the client has attention problems or is an older adult, breaking up the sessions is probably unnecessary.
Page Ref: 2683
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Learn continuously, learn cooperatively. | Nursing Process: Assessment
Learning Outcome: 41.A. Analyze patient/consumer education as it relates to teaching and learning. List special teaching strategies.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

5) The nurse wants to have a class on smoking cessation for residents of a community with different cultural groups. What action should the nurse take to adjust to their time orientation?
A) Plan classes throughout the day
B) Schedule classes for the evenings
C) Mail information about the classes
D) Assess cultural beliefs and practices
Answer: D
Explanation: A) Because the community is made of members of different cultural groups, daytime classes might not be appropriate.
B) Because the community is made up of members of different cultural groups, evening classes may not be appropriate.
C) Mailing information about the classes may not be well received. It depends upon the cultural group.
D) Transcultural teaching is an approach that takes into consideration barriers that arise when the teacher and the learner come from different cultural backgrounds. Prior to beginning any teaching, nurses should assess clients' cultural beliefs and practices to identify if there are any potential conflicts or other considerations that the nurse should incorporate into the teaching plan.
Page Ref: 2693
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Planning
Learning Outcome: 41.A. Analyze patient/consumer education as it relates to teaching and learning. List special teaching strategies.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

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6) The nurse is providing a series of educational workshops for caregivers of older clients interested in promoting the health and well-being of their clients. Which would be appropriate topics for this group? **Select all that apply.**
A) Fall prevention
B) Medication use and side effects
C) Safe driving evaluations
D) Advance directives
E) Responsible sexual behavior
Answer: A, B, C, D
Explanation: A) It is important for caregivers of older clients to learn how to prevent falls.
B) It is important for caregivers of older clients to learn about medication use and side effects.
C) It is important for caregivers of older clients to learn about safe driving evaluations.
D) It is important for caregivers of older clients to learn about advance directives.
E) It would be much less appropriate for this age group to include teaching about responsible sexual behavior, which would be better addressed to younger adult clients.
Page Ref: 2688
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Planning
Learning Outcome: 41.A. Analyze patient/consumer education as it relates to teaching and learning. Outline the steps of developing a teaching plan.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

7) The nurse is caring for a client with a new tracheostomy. After completing a teaching session on tracheostomy care, which information should the nurse include in the documentation?
A) The language used for teaching
B) The need for additional teaching
C) The client's questions after the teaching session
D) The supplies required for teaching
Answer: B
Explanation: A) Documenting the client's language is not necessary as it should already be in the nursing history.
B) The parts of the teaching process that should be documented in the client's chart include the need for additional teaching.
C) The client's questions are not documented, but the client's understanding at the end of the session is documented.
D) Supplies required for teaching are not documented.
Page Ref: 2694-2695
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.B.4. Document and plan patient care in an electronic health record. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Implementation
Learning Outcome: 41.A. Analyze patient/consumer education as it relates to teaching and learning. Summarize the aspects of identifying learning needs.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

8) The nurse is preparing discharge teaching for a child from a different cultural group. Which action should the nurse take prior to creating the teaching plan for this client and parents?
A) Provide written instructions before discharge.
B) Make sure the parents give their child medications.
C) Make sure the child comes back for the follow-up appointment.
D) Address any healing beliefs the family has.
Answer: D
Explanation: A) It is important to provide written material but the first priority is ascertaining any belief conflicts that may interfere with the client's treatment and follow-up care.
B) Ensuring the parents understand the medication schedule is important; however, the family's health beliefs first need to be addressed.
C) The first priority is ascertaining any belief conflicts that may interfere with the treatment and cause the parents to resist bringing the child back for a follow-up appointment.
D) If the prescribed treatment conflicts with the client/family's cultural healing beliefs, the client may not be compliant with the recommended treatments. To be effective, nurses must deal directly with any conflicts and differing values held by the client's parents.
Page Ref: 2693
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Planning
Learning Outcome: 41.A. Analyze patient/consumer education as it relates to teaching and learning. Outline the steps of developing a teaching plan.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

9) A client who needs to monitor blood glucose levels at home reports reading about the procedure on the internet and does not want any additional teaching. Which action should the nurse take at this time?
A) Document that the client understands teaching.
B) Teach the client's support system how to perform the procedure.
C) Give the client printed learning materials.
D) Watch the client perform a return demonstration of the skill.
Answer: D
Explanation: A) The nurse cannot document that the client understands teaching until a return demonstration by the client is correctly performed.
B) Teaching the support individual does not meet the requirement that the client will perform the skill.
C) Giving the client written directions does not meet the requirement that the client will perform the skill.
D) The nurse is responsible for documenting that the client can perform the skill that has been taught which can only be done by asking the client to demonstrate the procedure.
Page Ref: 2693
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Implementation

Learning Outcome: 41.A. Analyze patient/consumer education as it relates to teaching and learning. Differentiate environments where nurses teach.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

10) Which action should the nurse take when engaging in a teaching session with a client?
A) Keep to a strict schedule decided in advance.
B) Emphasize the importance of paying close attention if client reactions demonstrate confusion.
C) Evaluate client abilities to perform skills with return demonstrations.
D) Inform students that they need to take effective notes because you will not be repeating yourself.
Answer: C
Explanation: A) Nurses should take time for teaching, not simply adhere to strictly predefined schedules.
B) Nurses must be able to adapt teaching based on client reactions.
C) Return demonstrations are an effective way to evaluate whether clients are able to perform newly learned skills, and they contribute to a good environment for teaching.
D) Nurses should be prepared to repeat instructions.
Page Ref: 2690, 2693
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Implementation
Learning Outcome: 41.A. Analyze patient/consumer education as it relates to teaching and learning. Differentiate environments where nurses teach.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

11) The home health nurse is admitting a new client to the agency who was recently discharged from the hospital with a new diagnosis of pulmonary fibrosis. In which way should the nurse evaluate whether the client is able to set up and administer a nebulizer treatment?
A) Direct observation of behavior
B) Written description by the client of the treatment
C) Oral description by the client of the treatment
D) The client reports success or failure with the treatment at a follow-up appointment
Answer: A
Explanation: A) The best way for the nurse to evaluate whether this client is able to set up and administer a nebulizer treatment is by direct observation of the client doing it.
B) A written description of the treatment does not directly demonstrate that the client can set it up and administer it.
C) An oral description of the treatment does not directly demonstrate that the client can set it up and administer it.
D) The client reporting success or failure at a follow-up visit doesn't give the nurse a direct means of evaluating what the client understands.
Page Ref: 2694
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Evaluation
Learning Outcome: 41.A. Analyze patient/consumer education as it relates to teaching and learning. Summarize the aspects of identifying learning needs.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

12) The nurse is conducting a class for a group of pregnant clients and wants to focus specifically on the risks of alcohol consumption for the developing fetus. Which topic should the nurse include with regard to safety of the fetus?
A) Human growth and development
B) Nutrition
C) Lifestyle modification
D) Stress management
Answer: C
Explanation: A) Human growth and development does not directly address the risks of alcohol consumption.
B) Nutrition does not directly address the risks of alcohol consumption.
C) The nurse should focus on lifestyle modification if the focus is specifically on the risks of alcohol consumption for the developing fetus.
D) Stress management does not directly address the risks of alcohol consumption.
Page Ref: 2681
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Implementation
Learning Outcome: 41.A. Analyze patient/consumer education as it relates to teaching and learning. Summarize the aspects of identifying learning needs.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

13) A client with impaired hearing but intact visual acuity and motor function answers questions correctly when the speaker faces the client. Which action should the nurse take when instructing this client?
A) Give verbal instructions face to face with the client.
B) Provide only written instructions.
C) Use only visual media.
D) Use only physical demonstrations with written instructions.
Answer: A
Explanation: A) Verbal instructions are fine to use if the client is in a position to see the nurse's lips move.
B) Written instructions might be supplemental, however not the primary method used to teach.
C) Visual media might be supplemental, however not the primary method used to teach.
D) Physical demonstrations might be supplemental, however not the primary method used to teach.
Page Ref: 2685
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Implementation
Learning Outcome: 41.A. Analyze patient/consumer education as it relates to teaching and learning. Summarize the aspects of identifying learning needs.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

14) The nurse conducted a safety class for a group of older adult clients in the community on fall prevention. During a follow-up visit in the home of one of these clients, the nurse sees a number of fall hazards she identified during her class. Which statement should the nurse document regarding the learning outcome for this client?
A) The client might not have heard necessary information during the class.
B) The client did not understand the teaching given in the class.
C) The client understood the teaching given in the class but chose to ignore it.
D) The client did not comply with the teaching given in the class.
Answer: D
Explanation: A) The client might not have heard necessary information during the class because of a hearing deficit or being distracted, however the nurse would not know this without further evaluating the client.
B) The client might not have understood the information because of the way it was presented or for some other reason, however the nurse would need to further assess the client.
C) The client may have chosen not to comply with the teaching, however the nurse cannot know if this is the case without further evaluation of the client.
D) The client did not implement what he was taught in class given the evidence of fall hazards the class specifically addressed.
Page Ref: 2694-2695
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Evaluation
Learning Outcome: 41.A. Analyze patient/consumer education as it relates to teaching and learning. Summarize the aspects of identifying learning needs.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

15) The nurse is planning discharge teaching to a client with diabetes who has a large wound. Which action should the nurse make a priority before initiating teaching with this client?
A) Asking the client to state what is known about the current dressing changes
B) Teaching the client how to measure capillary blood glucose levels
C) Assessing the client's ability to self-administer insulin
D) Determining the client's reaction to having diabetes
Answer: A
Explanation: A) Nurses need to provide client education that will ensure the client's safe transition from one level of care to another and make appropriate plans for follow-up education in the client's home. Discharge plans must include information about what the client has been taught before transfer or discharge and what remains for the client to learn to perform self-care in the home or other residence.
B) Teaching how to measure blood glucose levels would not address the wound care needed.
C) Assessing ability to self-administer insulin would not address the wound care needed.
D) Determining the client's reaction to having the illness does not address the wound care needed.
Page Ref: 2683
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Assessment
Learning Outcome: 46.A. Analyze patient/consumer education as it relates to teaching and learning. Summarize the aspects of identifying learning needs.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

16) When asked to repeat the information taught during a discharge teaching session, the client states, "I have forgotten everything you just said." Which action by the nurse is appropriate at this time?
A) Repeating the information and having the client write it down as the nurse teaches
B) Having the client wait to ask questions until after the presentation
C) Assigning another nurse to provide the teaching for the client
D) Asking the client their preferred learning strategies
Answer: A
Explanation: A) Having the client write down information promotes retention.
B) Having the client wait to ask questions does not support learning.
C) Assigning another nurse to teach the client does not support learning.
D) The client's preferred learning strategy should have been assessed before teaching was provided.
Page Ref: 2694
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Learn continuously, learn cooperatively. | Nursing Process: Evaluation
Learning Outcome: 46.A. Analyze patient/consumer education as it relates to teaching and learning. Summarize the aspects of identifying learning needs.
MNL LO: Analyze the concept of teaching and learning and its application to nursing care.

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Module 42 Accountability

The Concept of Accountability

1) The nurse educator is teaching a group of students about professionalism. Which characteristics will the educator include that demonstrate accountability? **Select all that apply.**
A) The members of a profession are financially liable for their actions.
B) The members of a profession participate in ongoing research.
C) The members of a profession must acquire specialized education.
D) The members of a profession possess autonomy.
E) The members of a profession regularly socialize with one another.
Answer: C, D
Explanation: A) Financial liability is not a criterion that distinguishes nursing as a profession.
B) Participating in ongoing research is not a characteristic of a profession that demonstrates accountability.
C) A profession is generally distinguished from other kinds of occupations by its requirement of prolonged, specialized training to acquire a specific body of knowledge.
D) A profession is generally distinguished from other kinds of occupations by autonomy of its members.
E) Socialization with other nurses is not a criterion that distinguishes nursing as a profession.
Page Ref: 2703
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the health care team. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Implementation
Learning Outcome: 42.1. Analyze how the nursing profession promotes accountability.
MNL LO: Analyze the concept of accountability and its application to nursing care.

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2) A nurse would like to implement an evidence-based practice change that will influence client care on the medical-surgical unit. The nurse works with the nurse manager and other members of the leadership team to write a new policy and produce educational materials for the unit's staff and clients. In carrying out these actions, the nurse is practicing which Quality and Safety Education for Nurses competency?

A) Safety
B) Teamwork and Collaboration
C) Patient-Centered Care
D) Informatics

Answer: B

Explanation: A) The nurse's change in practice does not demonstrate the competency of safety.
B) The nurse is practicing teamwork and collaboration by working with other staff members to implement a policy change.
C) The nurse's change in practice does not demonstrate patient-centered care.
D) The nurse's change in practice does not demonstrate informatics.

Page Ref: 2702

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: II.A.1. Describe own strengths, limitations, and values in functioning as a member of a team. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Implementation

Learning Outcome: 42.1. Analyze how the nursing profession promotes accountability.

MNL LO: Analyze the concept of accountability and its application to nursing care.

3) A nurse faculty member is speaking to prospective students of the Bachelor of Science in Nursing (BSN) program at their educational institution. Which reasons should the nurse faculty member cite as a major incentive for students to select a BSN program over an Associate of Science in Nursing (ASN) program? **Select all that apply.**
A) Greater autonomy in the practice setting
B) Receipt of a fuller liberal arts education
C) Easier transition to graduate school
D) Ability to work in critical care areas
E) Better opportunity for career advancement
Answer: A, E
Explanation: A) Nurses who hold a BSN enjoy greater autonomy.
B) Having a liberal arts education is a plus, although not as major as an incentive for career advancement.
C) There are some institutions that offer RN-to-MSN educational programs, but the ease of transition is not the ultimate incentive, which is career advancement.
D) All RNs, regardless of their education level, can work in critical care areas.
E) Nurses who hold a BSN enjoy more career advancement than nurses who earn an ASN.
Page Ref: 2703
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.2. Describe scopes of practice and roles of health care team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 42.1. Analyze how the nursing profession promotes accountability.
MNL LO: Analyze the concept of accountability and its application to nursing care.

4) Which term explains how the structure of a profession establishes and maintains the social, political, and economic arrangements to control their professional affairs?
A) Autonomy
B) Governance
C) Socialization
D) Accountability
Answer: B
Explanation: A) Autonomy refers to a profession's ability to regulate itself and set standards of practice for its members.
B) Governance establishes and maintains the social, political, and economic arrangements that give professionals the means to control their professional affairs.
C) Socialization is the process by which individuals learn how to behave, feel, and see the world as members of their chosen profession.
D) Accountability involves being answerable for the outcomes of a task or assignment.
Page Ref: 2703-2704
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Assessment
Learning Outcome: 42.1. Analyze how the nursing profession promotes accountability.
MNL LO: Analyze the concept of accountability and its application to nursing care.

5) A nurse educator is conducting a continuing education in-service for the nurses in a pediatric intensive care unit. For which reason should the professional nurse attend these in-services?
A) Most states require it to maintain licensure.
B) It is a good way to receive overtime pay.
C) Research and new technology demand that nurses stay current.
D) New diseases are discovered every day.
Answer: C
Explanation: A) Although many states do have continuing education requirements for nurses, new technology and research are the most important reasons for staying current. In fact, these changes are the reasons why continuing education is required by most states.
B) Receiving overtime pay is not a reason to attend continuing education courses.
C) Research and technology are constantly changing and improving client care. Professional nurses are accountable for staying abreast of new information by attending continuing education courses.
D) Although new diseases are discovered regularly, nurses wouldn't necessarily need ongoing training on the diseases themselves, but rather on new ways of treating diseases.
Page Ref: 2705
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.C.5. Value the need for continuous improvement in clinical practice based on new knowledge. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and excellence in nursing. | Nursing Process: Implementation

Learning Outcome: 42.2. Outline the relationship between accountability and other concepts.
MNL LO: Analyze the concept of accountability and its application to nursing care.

6) A registered nurse (RN) who now works as a nursing supervisor at a local hospital is asked to talk about nursing during career day at a local high school. When explaining to the students why nursing is a profession rather than a job, which criteria should the RN include? **Select all that apply.**
A) Nursing has a well-defined body of knowledge.
B) Nurses receive high salaries.
C) More nurses are needed to meet current and predicted demand.
D) Nursing has a service orientation.
E) Nurses must have broad general knowledge of a variety of topics.
Answer: A, D
Explanation: A) As a profession, nursing has a well-defined body of knowledge and expertise that is always expanding. This knowledge base is the product of various conceptual nursing frameworks that inform practice, education, and ongoing research directed toward improving patient outcomes.
B) Salary level is not a criterion for a profession.
C) The number of practitioners in the field is not a criterion for a profession.
D) Several characteristics make nursing a profession rather than a job. For instance, a service orientation differentiates nursing from occupations pursued primarily for profit.
E) As with other professions, nursing's knowledge base is well-defined and specific rather than broad and general.
Page Ref: 2703
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the health care team. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Implementation
Learning Outcome: 42.1. Analyze how the nursing profession promotes accountability.
MNL LO: Analyze the concept of accountability and its application to nursing care.

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7) An adult decides to return to school to pursue a second career as a nurse. Which degree program is recommended for this learner as entry-level education for professional nursing?
A) Associate's degree
B) Baccalaureate degree
C) Master's degree
D) Doctoral degree
Answer: B
Explanation: A) Although an associate's degree is usually sufficient for nursing licensure, the ANA recommends a bachelor's degree to enter professional practice.
B) Although an associate's degree is usually sufficient for nursing licensure, the ANA recommends a bachelor's degree to enter professional practice. Having a bachelor's degree can also lead to more career opportunities, because many magnet hospitals and academic health centers require that their RNs have at least this level of education.
C) A master's degree is usually undertaken to provide specialized nursing education, such as that required to become a nurse practitioner.
D) A doctorate involves advanced training, which may focus on clinical or organizational skills and usually involves research.
Page Ref: 2703
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Assessment
Learning Outcome: 42.1. Analyze how the nursing profession promotes accountability.
MNL LO: Analyze the concept of accountability and its application to nursing care.

8) Which factor encourages the adoption of the attitudes and behaviors that characterize professionalism in nursing?
A) Employment opportunities
B) Licensure requirements
C) Interaction with peers
D) Specialized training
Answer: C
Explanation: A) Employment opportunities are not associated with adopting the attitudes and behaviors of professional nursing.
B) Licensure requirements are not associated with adopting the attitudes and behaviors of professional nursing.
C) One of the most powerful mechanisms of professional socialization is interaction with fellow students and nurses to learn the social rules defining the relationships into which they will enter.
D) Specialized training provides nurses with the knowledge and skills necessary to do their job, but it doesn't necessarily lead a nurse to internalize the attitudes and behaviors that characterize professionalism in nursing.
Page Ref: 2706
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the health care team. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Assessment

Learning Outcome: 42.3. Analyze the process of socialization to nursing.
MNL LO: Analyze the concept of accountability and its application to nursing care.

9) In which way does accountability differ from responsibility?
A) Responsibility involves specific tasks that must be completed in order to fulfill a role, whereas accountability involves being answerable for the outcomes of those tasks.
B) Accountability involves specific tasks that must be completed in order to fulfill a role, whereas responsibility involves being answerable for the outcomes of those tasks.
C) Responsibility involves the professional standards used to determine what a nurse should or should not do, whereas accountability involves taking ownership of the actions of others.
D) Accountability involves the professional standards used to determine what a nurse should or should not do, whereas responsibility involves taking ownership of the actions of others.
Answer: A
Explanation: A) Accountability involves being answerable for the outcomes of a task or assignment.
B) Accountability involves being answerable for the outcomes of a task or assignment.
C) Nurses are accountable for their own actions and behaviors, but they may also be accountable for the actions of others, such as subordinates or trainees.
D) Responsibility is the specific obligation associated with the performance of duties of a particular role, and it belongs to the individual performing the duties. Nurses are responsible for performing their assigned tasks reliably, dependably, and to the best of their abilities.
Page Ref: 2701
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.B.4. Function competently within own scope of practice as a member of the health care team. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Apply professional standards; Show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Assessment
Learning Outcome: 42.1. Analyze how the nursing profession promotes accountability.
MNL LO: Analyze the concept of accountability and its application to nursing care.

Exemplar 42.A Competence

1) A novice nurse on a medical-surgical unit is released from the orientation phase of training. The nurse is able to care for a four- to five-client assignment independently and is assigned a coach on the unit who will help with problem solving if needed. According to Benner's stages of nursing expertise, this nurse would belong in which stage?
A) Stage II
B) Stage V
C) Stage III
D) Stage IV
Answer: A
Explanation: A) The new graduate nurse who is fresh out of the orientation phase is considered to be in Stage II. Stage II nurses are advanced beginners, meaning they demonstrate marginally acceptable performance.
B) Nurses at Stage V are considered experts. Their performance is fluid, flexible, and highly proficient. The expert nurse no longer requires rules, guidelines, or maxims to connect an understanding of the situation to appropriate action. These individuals have highly intuitive and analytic abilities in new situations.
C) Stage III is the competency stage; nurses in this stage have 2 or 3 years of experience and demonstrate organizational and planning abilities.
D) Stage IV nurses have 3 to 5 years of experience, have a holistic understanding of the client that improves decision making, and focus on long-term goals.
Page Ref: 2711
Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.1. Describe own strengths, limitations, and values in functioning as a member of a team. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Apply professional standards; show accountability for nursing judgment and actions; Develop advocacy skills. | Nursing Process: Assessment
Learning Outcome: 42.A. Analyze competence as it relates to accountability. Explain the importance of lifelong competence for nurses.
MNL LO: Analyze the concept of accountability and its application to nursing care.

2) One of the roles of the community health nurse is to educate individuals about health promotion and wellness. Which activity would the nurse dismiss as irrelevant to health promotion and wellness?

A) Holding classes for teenagers regarding prevention of sexually transmitted infections
B) Teaching a class about smoking cessation
C) Initiating infant care classes for new parents
D) Implementing an exercise class for clients who have had a heart attack

Answer: D

Explanation: A) Holding classes for teenagers regarding prevention of sexually transmitted infections is a health promotion and wellness activity.
B) Teaching clients about smoking cessation is a health promotion and wellness activity.
C) Initiating infant care classes for new parents is a health promotion and wellness activity.
D) Teaching clients about recovery activities, such as exercises that accelerate recovery after a heart attack, would be an action to restore health and not promote health.

Page Ref: 2705
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Context and Environment: Knowledge: Environmental health; Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); Chronic disease management; Health care systems; Transcultural approaches to health; Family dynamics. | Nursing Process: Evaluation
Learning Outcome: 42.A. Analyze competence as it relates to accountability. Describe the areas of competence.

MNL LO: Analyze the concept of accountability and its application to nursing care.

3) A nurse educator is talking to a group of staff nurses about the importance of continued competence in nursing practice. One of the staff nurses asks about activities that can help professional nurses maintain competence. Which action should the nurse educator recommend?
A) Working overtime whenever hours are available
B) Designing a poster presentation on current research on care for the dying client
C) Volunteering to take blood pressures at a health and wellness fair
D) Organizing a seminar to educate new nurses about hospital policies
Answer: B
Explanation: A) Working overtime does not necessarily contribute to continued competence and may not be beneficial for the nurse or clients if the nurse experiences burnout.
B) Designing a poster presentation on current research involves gathering information on a nursing topic. The nurse may be preparing to teach others, but in doing so, he or she is gaining more knowledge and furthering personal competence.
C) Volunteering to take blood pressures will not further the nurse's competence.
D) Organizing an educational seminar involves scheduling, recruiting speakers, and arranging for a location, but it does not contribute to continued competence; however, attending such a seminar may.
Page Ref: 2711
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.C.5. Value the need for continuous improvement in clinical practice based on new knowledge. | AACN Domains and Competencies: 9.3 Demonstrate accountability to the individual, society, and the profession. | NLN Competencies: Personal and Professional Development: Knowledge: Impact of continual knowledge explosion and constant evolution of technology. | Nursing Process: Planning
Learning Outcome: 42.A. Analyze competence as it relates to accountability. Explain the importance of lifelong competence for nurses.
MNL LO: Analyze the concept of accountability and its application to nursing care.

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4) A nurse, who has been working in a small rural hospital for 4 years since obtaining a nursing license, participates on an interdisciplinary task force to improve client care. Which skill level is this nurse demonstrating according to Benner's stages of nursing expertise?
A) Advanced beginner
B) Competent
C) Proficient
D) Expert
Answer: C
Explanation: A) An advanced beginner nurse has less than 2 years of experience and demonstrates marginally acceptable performance.
B) A competent nurse has 2 or 3 years of experience and demonstrates organizational and planning abilities.
C) According to Benner's stages, this nurse would be considered proficient, because they have 3 to 5 years of experience and a holistic understanding of the client, which improves decision making.
D) An expert nurse has more than 5 years of experience and demonstrates highly skilled intuitive and analytic ability in new situations.
Page Ref: 2711
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.C.5. Value the need for continuous improvement in clinical practice based on new knowledge. | AACN Domains and Competencies: 9.3 Demonstrate accountability to the individual, society, and the profession. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and excellence in nursing. | Nursing Process: Assessment
Learning Outcome: 42.A. Analyze competence as it relates to accountability. Explain the importance of lifelong competence for nurses.
MNL LO: Analyze the concept of accountability and its application to nursing care.

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5) A school nurse in a large urban high school regularly delivers presentations on nutrition, smoking cessation, and prevention of sexually transmitted infections (STIs). What areas of nursing competence is this nurse demonstrating? **Select all that apply.**
A) Health restoration
B) Health and wellness promotion
C) Caring for the dying
D) Illness prevention
E) Care cost savings
Answer: B, D
Explanation: A) Health restoration focuses on ill clients, which is not the case in this situation.
B) This nurse is demonstrating competence in health and wellness promotion, because these programs enable students to increase their control over the determinants of health and thus improve their health.
C) Caring for the dying involves helping clients live as comfortably as possible until death, and it is not applicable in this situation.
D) The nurse is demonstrating competence in illness prevention in that the programs are designed to maintain optimal health by preventing disease.
E) Care cost saving is not a core area of nursing competence.
Page Ref: 2705
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 9.3 Demonstrate accountability to the individual, society, and the profession. | NLN Competencies: Context and Environment: Knowledge: Environmental health; Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); Chronic disease management; Health care systems; Transcultural approaches to health; Family dynamics. | Nursing Process: Implementation
Learning Outcome: 42.A. Analyze competence as it relates to accountability. Describe the areas of competence.
MNL LO: Analyze the concept of accountability and its application to nursing care.

6) An experienced nurse practitioner is always conscious of the need to maintain a high level of competence within professional nursing practice. Which activities support this nurse's goal? **Select all that apply.**

A) Reading professional journals
B) Collaborating with peers
C) Counseling clients
D) Attending professional workshops and seminars
E) Administering medications appropriately

Answer: A, B, D

Explanation: A) Lifelong competence can be promoted by reading professional and peer-reviewed journals.

B) Lifelong competence can be promoted by having formal and informal discussions with peers and other members of the healthcare team.

C) Providing counseling to clients is a way to implement nursing knowledge, not a method for increasing it.

D) Lifelong competence can be promoted by attending seminars offered by colleges and professional organizations.

E) Administering medications is a way to implement nursing knowledge, not a method for increasing it.

Page Ref: 2711
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.C.5. Value the need for continuous improvement in clinical practice based on new knowledge. | AACN Domains and Competencies: 9.3 Demonstrate accountability to the individual, society, and the profession. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and excellence in nursing. | Nursing Process: Implementation
Learning Outcome: 42.A. Analyze competence as it relates to accountability. Explain the importance of lifelong competence for nurses.
MNL LO: Analyze the concept of accountability and its application to nursing care.

7) Which concept explains a state of being in which individuals engage in behaviors that enhance their quality of life and maximize their personal potential?
A) Health promotion
B) Wellness
C) Prevention
D) Health restoration
Answer: B
Explanation: A) Health promotion is a process that enables individuals and communities to increase their control over the determinants of well-being, thereby improving their overall health.
B) Wellness can be described as a state of being in which individuals engage in activities and behaviors that enhance their quality of life and maximize their personal potential, including their physical fitness and emotional health.
C) Prevention focuses on maintaining health by working to stop illnesses and injuries from occurring.
D) Health restoration involves efforts to return clients to their optimal state of health following illness or injury.
Page Ref: 2705
Cognitive Level: Remembering
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Knowledge: Environmental health; Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); Chronic disease management; Health care systems; Transcultural approaches to health; Family dynamics. | Nursing Process: Implementation
Learning Outcome: 42.A. Analyze competence as it relates to accountability. Describe the areas of competence.
MNL LO: Analyze the concept of accountability and its application to nursing care.

8) The nurse is caring for clients with critical illnesses. Which core skill will the nurse need to develop to meet the clients' needs?
A) Autonomy
B) Presencing
C) Accountability
D) Problem solving
Answer: D
Explanation: A) Autonomy is a criterion for a profession but will not necessarily help the nurse care for critically ill clients.
B) Presencing is a strategy to support the nurse-client relationship.
C) Accountability is a criterion for a profession but will not necessarily help the nurse care for critically ill clients.
D) Problem solving is a core skill of competency for working with clients in complex environments. It can be developed and enhanced over time through the use of evidence-based learning and practice.
Page Ref: 2711
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Knowledge: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 42.A. Analyze competence as it relates to accountability. Describe the areas of competence.

MNL LO: Analyze the concept of accountability and its application to nursing care.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 43 Advocacy

The Concept of Advocacy

1) The nurse is caring for a terminally ill, pediatric client. The parents have decided to remove their child from life support. Which action by the nurse displays the role of client advocate?
A) Respecting the parents' decision
B) Telling the parents that they are making the right decision
C) Asking to be assigned to a different client
D) Referring the parents to social services
Answer: A
Explanation: A) The nurse best advocates for the family by supporting the family's right to make this decision.
B) Telling the parents that they are making the right decision is inappropriate and does not support advocacy.
C) Asking to be assigned to another client does not honor the right of clients and families to make decisions about healthcare.
D) Referring the parents to another entity points to feelings of unease about the parents' choice.
Page Ref: 2719
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.C.14. Appreciate shared decision-making with empowered patients and families, even when conflicts occur. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 43.1. Analyze the role of the advocate in the practice of nursing.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

2) By providing volunteer client care to an inadequately insured population, the nurse is demonstrating which value of client advocacy?
A) The client has the right to make choices and decisions.
B) The nurse has the responsibility to ensure the client has access to healthcare services.
C) The client has the right to expect a nurse-client relationship based on shared respect.
D) The nurse has the responsibility to make choices and decisions.
Answer: B
Explanation: A) Although the client does have the right to make choices and decisions, the nurse volunteering at a free clinic to provide healthcare to the underinsured does not demonstrate this value.
B) The nurse has the responsibility to ensure the client has access to healthcare services that meet health needs.
C) Although the client does have the right to expect a nurse-client relationship based on shared respect, the nurse volunteering at a free clinic to provide healthcare to the underinsured does not demonstrate this value.
D) The nurse's responsibility to make choices and decisions is not one of the values basic to client advocacy.
Page Ref: 2723
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.C.14. Appreciate shared decision-making with empowered patients and families, even when conflicts occur. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation

Learning Outcome: 43.2. Summarize advocacy interventions used by nurses.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

3) A charge nurse notices that a client has a black eye that was not present when admitted to the facility. Which action by the charge nurse is appropriate in this situation?
A) Ask a staff nurse to question the client about the situation.
B) Discuss the situation with the client in a private setting.
C) Ask the other staff members if abuse is involved.
D) Ignore the situation until the client shows a willingness to talk.
Answer: B
Explanation: A) The charge nurse herself should address this situation.
B) The charge nurse should discuss the situation with the client in private and offer options of help.
C) The nurse should speak to the client first, not the staff, and not assume abuse until the client has given her version of events.
D) The charge nurse should not ignore the situation and should advocate for the client.
Page Ref: 2721
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.C.14. Appreciate shared decision-making with empowered patients and families, even when conflicts occur. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 43.1. Analyze the role of the advocate in the practice of nursing.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

4) Which action is an advocacy intervention that a nurse may perform?
A) Ensuring that clients and their families understand their legal rights.
B) Deciding whether clients need to know information regarding their care.
C) Following organizational policies and procedures in all cases without question.
D) Leaving monitoring of clients' care to the clients themselves.
Answer: A
Explanation: A) Educating clients and their families about their legal rights regarding informed decision-making is a specific advocacy intervention a nurse may make.
B) Nurses should ensure that clients have all the information they need to give informed consent.
C) They should review organizational policies and procedures to ensure protection of client rights.
D) Nurses should monitor client care to ensure client rights.
Page Ref: 2722
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.14. Appreciate shared decision-making with empowered patients and families, even when conflicts occur. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 43.2. Summarize advocacy interventions used by nurses.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

5) The nurse notices that there is broken equipment on the playground in a neighborhood where care is provided to low-income residents. The nurse tries unsuccessfully to get the owner to address this safety issue. Which additional action is most consistent with the role of the nurse as a public advocate?
A) Write an article in the local newspaper to gain public attention.
B) No action is required; this is a civil problem beyond the realm of the nurse.
C) Call the police to report the owner's neglect.
D) Tell the parents they should not pay their rent until the playground is fixed.
Answer: A
Explanation: A) Prevention of injury to clients is very much a part of nursing. The nurse should initially contact the owner. Because this was ineffective, it is appropriate for the nurse to write an article or talk to an individual on the town council.
B) Civil problem or not, the nurse has an obligation to protect the neighborhood children from injury and should act on it.
C) The police are a protection against crime and are not likely to do anything about the situation.
D) Telling the parents not to pay their rent until the playground is fixed is not appropriate.
Page Ref: 2719
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: II.C.6. Value teamwork and the relationships upon which it is based. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 43.3. Outline the relationship between advocacy and other concepts.
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MNL LO: Analyze the concept of advocacy and its application to nursing care.

6) The nurse has been working in a long-term care facility for one week. The nurse notes that, during the evening meal, an unlicensed assistive personnel (UAP) gives a tray to a client who is unable to cut up and eat the food independently, and then leaves. After the nurse assists the client with eating the meal, which action is appropriate to advocate for this client?
A) Report the UAP for neglect.
B) Notify the healthcare provider.
C) Call the client's family to have them assist with evening meals.
D) Discuss the situation with the director of nursing.
Answer: D
Explanation: A) The UAP is not neglecting the client. The UAP is assigned tasks by the nurse in charge of the client.
B) Notifying the doctor will not help the client.
C) The family might be able to help at times but cannot be expected to come for every meal.
D) The nurse would advocate getting the client's plan changed because the goal is to have someone available to help the client eat for every meal The nurse assesses that this happens at every meal and seeks to change how this client is cared for, not just changing one healthcare worker.
Page Ref: 2723
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.10. Engage patients or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 43.1. Analyze the role of the advocate in the practice of nursing.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

7) The nurse is caring for a client on a mental health unit who is yelling at other clients and some of the staff. Which verbal intervention by the nurse is most consistent with the concept of advocacy?
A) "You should be ashamed of your behavior. No wonder you ended up on a mental health unit."
B) "You seem upset. Can you tell me what you think might help to calm you down?"
C) "You need to behave. If this doesn't stop you are going to be placed in restraints."
D) "You are out of control. You have no choice but to take more medication."
Answer: B
Explanation: A) Disparaging the client is inconsistent with client rights.
B) The nurse's role is to advocate for the rights of the individual with mental illness or disability. The nurse should validate the meaning of the behavior and encourage safe coping methods.
C) Threatening to restrain them is inconsistent with client rights.
D) Threatening to sedate them is inconsistent with client rights.
Page Ref: 2721
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.B.10. Engage patients or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 43.1. Analyze the role of the advocate in the practice of nursing.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

8) An older adult client with metastasized breast cancer informs the nurse that her doctor is insisting that she participate in a course of chemotherapy, even though the client does not want to have any further treatment. Which actions by the nurse exemplify advocacy for this client?
Select all that apply.
A) Tell the client that it is in her best interest to follow the doctor's advice.
B) Inform the doctor about the client's clear wishes not to have further chemotherapy.
C) Ascertain whether the client has an advance care directive and, if not, assist her in creating one.
D) Discuss the implications of various choices with the client.
E) Avoid interfering in the doctor-client relationship.
Answer: B, C, D
Explanation: A) The nurse should not tell the client to follow the doctor's advice.
B) The nurse should continuously advocate for the client in a professional manner.
C) The nurse serves as both a teacher and an advocate by informing clients about their rights.
D) When the client makes decisions about his or her treatment other than what is recommended, it is the nurse's role to ensure that the client is making an informed decision and, if so, to advocate for the client's right to make autonomous choices.
E) The nurse talking with the doctor is not interfering in the doctor-client relationship.
Page Ref: 2721-2722
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.10. Value active partnership with patients or designated surrogates in planning, implementation, and evaluation of care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation

Learning Outcome: 43.2. Summarize advocacy interventions used by nurses.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

9) Which advocacy interventions might nurses provide that are within their role and scope of practice? **Select all that apply.**

A) Educating clients and their families about their legal rights regarding informed decision-making

B) Ensuring that clients have the necessary information to make an informed decision or give informed consent

C) Evaluating organizational policies and procedures to ensure protection of client rights

D) Supporting medical authority even when this goes against the client's wishes

E) Declaring clients incompetent so family members can make medical decisions for them

Answer: A, B, C

Explanation: A) Clients must understand their rights in order to be able to defend them.

B) As an advocate, the nurse provides clients with the information they need to make informed decisions and supports the clients' rights to make their own healthcare decisions.

C) Nurses should evaluate organizational policies and procedures and monitor clients' care to ensure protection of client rights.

D) A nurse should understand that advocacy may require political action. Conflicts may arise over issues that require consultation, confrontation, or negotiation between the nurse and administrative personnel or between the nurse and primary care providers.

E) Declaring clients incompetent is not the role of the nurse, and it should not be done just to please family members.

Page Ref: 2721-2722

Cognitive Level: Understanding

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: II.C.2. Appreciate importance of intra- and interprofessional collaboration. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation

Learning Outcome: 43.2. Summarize advocacy interventions used by nurses.

MNL LO: Analyze the concept of advocacy and its application to nursing care.

10) The nurse suspects another healthcare provider is under the influence of alcohol at work. Which actions by the nurse are correct? **Select all that apply.**
A) Assume that healthcare provider is handling any problem.
B) Immediately report it to a supervisor.
C) Respect the privacy of the healthcare provider.
D) Assist the provider while care is provided to clients.
E) Follow the state board guidelines.
Answer: B, E
Explanation: A) The nurse should not assume that the healthcare provider is handling problems.
B) A nurse who suspects a colleague of engaging in illegal, immoral, or unethical conduct and fails to act is in direct violation of the ANA Code of Ethics for Nurses. Nurses have a legal responsibility to report any professional whom they suspect of engaging in illegal, immoral, or unethical activities.
C) Although an impaired healthcare provider may view this intervention as an invasion of privacy, such prompt action will safeguard the client from harm, at the same time offering the impaired healthcare provider a chance at recovery.
D) The nurse needs to do more than help the healthcare provider with care.
E) Nurses should follow guidelines set forth by the board of nursing for the state in which they work.
Page Ref: 2723
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 43.4. Describe the nurse's role in reporting unprofessional activities.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

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11) A school nurse who is concerned about an increase in sports injuries related to ineffective protective equipment decides to hold a community seminar related to the importance of proper protective equipment. Which advocacy activities is this nurse demonstrating? **Select all that apply.**

A) Advocating for vulnerable populations
B) Advocating for fair and equitable access to high-quality care for all clients
C) Ensuring that clients have the necessary information to make an informed decision or give informed consent
D) Informing the public about issues and concerns
E) Speaking publicly for the health, welfare, and safety of clients
Answer: A, C, D, E
Explanation: A) Clients from vulnerable populations, such as children, particularly benefit from nursing advocacy.
B) Advocating for fair and equitable access to high-quality care is also an important advocacy activity, but it is not being demonstrated in this situation.
C) Through this seminar, the nurse is providing clients with information to make an informed decision and informing the public about issues and concerns that are important to them.
D) The nurse is speaking publicly to encourage safety practices for students.
E) The nurse is speaking publicly to encourage safety practices for students.
Page Ref: 2719
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.B.10. Engage patients or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 43.2. Summarize advocacy interventions used by nurses.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

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12) The nurse is planning to carry out advocacy interventions when caring for a client with brain cancer. Which value should the nurse recognize as most basic to client advocacy?
A) The client is a holistic, autonomous being who has the right to make choices and decisions.
B) The nurse has the responsibility to ensure the client's decisions guide care regardless of whether the client is mentally competent.
C) Clients should be advised that making their own care decisions is almost invariably detrimental to their well-being.
D) The client is a dependent being who has the right to expect the nurse to solve all healthcare needs.
Answer: A
Explanation: A) Safeguarding clients' autonomy is the first core attribute of advocacy.
B) Advocacy requires respecting and promoting each client's right to self-determination, except in those situations when the client is incompetent to decide or does not wish to be involved in decision making.
C) Clients should not be discouraged from making their own decisions.
D) Clients should not be treated as naturally dependent.
Page Ref: 2722
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.14. Appreciate shared decision-making with empowered patients and families, even when conflicts occur. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation

Learning Outcome: 43.1. Analyze the role of the advocate in the practice of nursing.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

13) The home health nurse suspects that another nurse providing home care to a client has been taking the client's narcotics. Which action should the nurse carry out?
A) Follow the reporting procedures for her agency.
B) Tell the client to confront the other nurse.
C) Confront the other nurse about the suspected theft.
D) Have the client file a police report.
Answer: A
Explanation: A) Nurses have a legal responsibility to report any professional whom they suspect of engaging in illegal, immoral, or unethical activities. Normally, the nurse making such a report will do so following established procedures at the facility at which the nurse is employed. Both state nurse practice acts and the ANA Code of Ethics require nurses to report unethical nurse behaviors, including boundary violations.
B) The nurse should not leave the responsibility of addressing this problem to the client.
C) The nurse should not directly confront the other nurse.
D) The nurse should not leave the responsibility of addressing this problem to the client.
Page Ref: 2723
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 43.4. Describe the nurse's role in reporting unprofessional activities.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

Exemplar 43.A Environmental Quality

1) The nurse involved in promoting client advocacy efforts in the community is assessing the vulnerability of populations in the area served by the healthcare facility where he works. This is a high-ozone area. Which client would have the lowest risk for ground-level ozone?
A) A 73-year-old female client with a high level of financial security
B) A 23-year-old male client with a regular salaried job able to pay his bills
C) A 33-year-old female client with COPD and without a job living at the poverty line
D) A 13-year-old male client whose parents both work at mid-level professional jobs
Answer: B
Explanation: A) Individuals at higher risk within high-ozone geographic areas include the elderly (the 73-year-old female client).
B) Individuals at higher risk within high-ozone geographic areas include those with diminished lung function who are also socioeconomically disadvantaged (the 33-year-old female client), the elderly (the 73-year-old female client), children (the 13-year-old client), or those with comorbidities. Therefore, the 23-year-old male client would have the lowest risk for ground-level ozone.
C) Individuals at higher risk within high-ozone geographic areas include those with diminished lung function who are also socioeconomically disadvantaged (the 33-year-old female client).
D) Individuals at higher risk within high-ozone geographic areas include children (the 13-year-old client).
Page Ref: 2725
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Evidence and best practice for nursing. | Nursing Process: Assessment
Learning Outcome: 43.A. Analyze the health indicator of environmental quality as it relates to advocacy. Summarize the major impacts of environmental quality on public health.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

2) The nurse is organizing a client advocacy committee focused on improvements in water quality to protect the health of vulnerable populations. Which area of improvement should the nurse identify in the healthcare environment?

A) Disposal of disinfectants

B) Oil spills

C) Flushing of medications in the toilet

D) Use of arsenic

Answer: A

Explanation: A) Water supplies may be contaminated with either natural or human-made substances. Contaminants in the public drinking supply that can cause health hazards include disinfection by-products.

B) The nurse's facility is not likely to be involved in oil spills.

C) The nurse's facility is not likely to flush medications in the toilet. Medications that are not used would be returned to the pharmacy.

D) The nurse's facility is not likely to use arsenic.

Page Ref: 2725

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: QSEN Competencies: I.C.14. Appreciate shared decision-making with empowered patients and families, even when conflicts occur. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation

Learning Outcome: 43.A. Analyze the health indicator of environmental quality as it relates to advocacy. Outline the components of environmental quality.

MNL LO: Analyze the concept of advocacy and its application to nursing care.

3) The nurse is organizing a community effort to reduce the rate of birth defects in the area. A nuclear power plant provides most of the electricity for the community. Which aspect of this power plant's operation should the nurse identify as problematic?
A) Production of particulate matter such as smoke
B) Production of ionizing radiation
C) Production of hazardous waste
D) Production of nuclear-generated electricity
Answer: C
Explanation: A) If this power plant produces particulate matter, that could increase the risk of asthma.
B) If the plant produces ionizing radiation to which people in the community become exposed, that could increase the risk of cancer.
C) Birth defects may be caused by living near hazardous waste. If this power plant produces such waste, that could increase the rate of birth defects for this community.
D) Production of nuclear-generated electricity is a benefit produced by the power plant, not an environmental hazard.
Page Ref: 2726
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment

Learning Outcome: 43.A. Analyze the health indicator of environmental quality as it relates to advocacy. Describe community responses to alterations in environmental quality.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

4) Which action by the nurse working in the emergency department best demonstrates advocacy for better environmental quality?
A) Improving prioritization skills for nurses in the ED
B) Adapting practices in the ED to cultural needs of clients
C) Revising policies for telephone triage to ensure better distribution of resources
D) Ensuring that bandages and dressings are properly disposed of according to protocol
Answer: D
Explanation: A) Improved prioritization skills for nurses is a useful intervention but does not relate to environmental quality.
B) More culturally aware practices are useful interventions but do not relate to environmental quality.
C) Having telephone triage policies that make better use of ED resources is a useful intervention but does not relate to environmental quality.
D) A nurse working in an ED may advocate for better environmental quality for clients by ensuring that bandages and dressings are properly disposed of according to protocol.
Page Ref: 2725
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Evaluation
Learning Outcome: 43.A. Analyze the health indicator of environmental quality as it relates to advocacy. Explain the nurse's role in advocating for patients affected by environmental quality.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

5) The nurse is working in a community health setting. Which situation should the nurse identify as a threat to environmental quality?
A) Many residences appear to be vulnerable to intrusion, with open garage doors or ground-floor windows.
B) Children in many neighborhoods are playing in the street with no adult supervision.
C) Many people walking their pets do not clean up their pets' waste.
D) On many residential streets, cars are parked in a way that blocks traffic and creates potential driving hazards.
Answer: C
Explanation: A) Vulnerability to intrusion does not relate to environmental quality.
B) Children playing in the street does not relate to environmental quality.
C) Improper disposal of pet waste is a danger to clean water that the National Resource Defense Council has identified as an area of concern. This would be an environmental quality concern.
D) Improperly parked cars do not relate to environmental quality.
Page Ref: 2726
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.1. Integrate understanding of multiple dimensions of patient-centered care: Patient/family/community preferences, values; Coordination and integration of care; Information, communication, and education; Physical comfort and emotional support; Involvement of family and friends; Transition and continuity. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Effective communication. | Nursing Process: Assessment
Learning Outcome: 43.A. Analyze the health indicator of environmental quality as it relates to advocacy. Describe community responses to alterations in environmental quality.
MNL LO: Analyze the concept of advocacy and its application to nursing care.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 44 Ethics

The Concept of Ethics

1) A client with traumatic injuries has no communication between the brain and spinal cord because of a severe cervical fracture. The healthcare provider confers with the family and agrees that the client should be extubated. For which reason would the nurse experience difficulty with this task?
A) An ethical conflict
B) Issue with personal values
C) Legal issues
D) Cultural values
Answer: B
Explanation: A) The decision is within ethical principles.
B) The nurse is distressed because of personal values, which are in conflict with causing the client's death. The nurse would need to focus on values clarification to help identify personal values specific to life, death, health, and illness.
C) Extubating this client would not be a legal decision.
D) Cultural values are not in evidence in this situation.
Page Ref: 2730
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Code of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 44.1. Analyze the relationship between values and ethics in nursing.
MNL LO: Analyze the concept of ethics and its application to nursing care.

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2) The nurse is caring for an older adult client with terminal cancer. The client's family wants to continue treatment, but the client would like to discontinue treatment and go home. The nurse agrees to be present while the client tells the family. Which principle is the nurse supporting?
A) Beneficence
B) Autonomy
C) Nonmaleficence
D) Justice
Answer: B
Explanation: A) Beneficence means "doing good."
B) Autonomy refers to the right to make one's own decisions. The nurse is supporting this principle by supporting the client in the decision.
C) Nonmaleficence is the duty to "do no harm."
D) Justice is often referred to as fairness.
Page Ref: 2735
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.2. Respect and encourage individual expression of patient values, preferences, and expressed needs. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Code of Ethics, regulatory and professional standards, ethical decision-making models; Scope of practice considerations; Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Implementation
Learning Outcome: 44.1. Analyze the relationship between values and ethics in nursing.
MNL LO: Analyze the concept of ethics and its application to nursing care.

3) Which statement accurately describes the purpose of the American Nurse's Association's *Code of Ethics for Nurses*?

A) It serves as a statement of nurses' personal values and standards.

B) It serves as the profession's nonnegotiable ethical standard.

C) It serves as an announcement of nurses' commitment to the profession.

D) It serves as a standard protocol for performing nursing procedures.

Answer: B

Explanation: A) The ANA *Code of Ethics for Nurses* is not a statement of nurses' personal values and standards.

B) The ANA *Code of Ethics for Nurses* serves as a statement of nurses' ethical obligations and duties, as the profession's nonnegotiable ethical standard, and as the nursing profession's statement of commitment to society.

C) The ANA *Code of Ethics for Nurses* is not an announcement of nurses' commitment to the profession.

D) Nurses should refer to the ANA *Code of Ethics for Nurses* to direct how they perform their duties in daily practice, but it does not provide standard protocols for performing nursing procedures.

Page Ref: 2733

Cognitive Level: Understanding

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Personal and Professional Development: Code of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Assessment

Learning Outcome: 44.3. Differentiate the various codes of ethics used in nursing.

MNL LO: Analyze the concept of ethics and its application to nursing care.

4) A nurse is volunteering time in a local free clinic that provides care to the underinsured population. By volunteering time to work in the clinic, this nurse is demonstrating which professional value?

A) Human dignity
B) Social justice
C) Integrity
D) Autonomy

Answer: B

Explanation: A) Human dignity is respect for the worth and uniqueness of individuals and populations.

B) Social justice is upholding fairness on a social scale. This value is demonstrated in professional practice when the nurse works to ensure equal treatment under the law and equal access to quality healthcare.

C) Integrity is acting in accordance with an appropriate code of ethics and accepted standards of practice.

D) Autonomy is respecting the client's right to make decisions about their healthcare.

Page Ref: 2730
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Demonstrate respect for all persons and for human dignity, equality, and justice. | Nursing Process: Implementation
Learning Outcome: 44.1. Analyze the relationship between values and ethics in nursing.
MNL LO: Analyze the concept of ethics and its application to nursing care.

5) A nurse educator is talking to a student about how to deal with an ethical dilemma in practice. Which step does the nurse educator explain to the student as important regarding actions during an ethical dilemma?
A) Examining all conflicts in the situation
B) Investigating all aspects of the situation
C) Relying on nursing judgment
D) Making a decision based on the policy of the agency
Answer: B
Explanation: A) Examining the conflicts surrounding the issue is only one aspect of the situation to consider.
B) To avoid making a premature decision, the nurse should investigate all aspects of the dilemma before deciding.
C) Overconfidence can lead to poor decision making.
D) Reading the agency policy regarding the matter addresses only one aspect of the situation.
Page Ref: 2736
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 44.5. Summarize strategies to enhance ethical decisions in practice.
MNL LO: Analyze the concept of ethics and its application to nursing care.

6) The nurse is caring for a client on a medical-surgical unit. The client tells the nurse that the healthcare provider has refused to treat the client further if the client continues to be noncompliant with the healthcare provider's recommendations. Which action should the nurse take?
A) Take the issue to the hospital ethics committee.
B) Advise the client to sue the healthcare provider.
C) Have the client contact a consumer agency.
D) Notify the healthcare provider of the client's complaints.
Answer: A
Explanation: A) Acting as a client advocate and protecting the client's rights, the nurse should enlist the help of the hospital ethics committee.
B) The nurse never advises a client to sue but assists the client to find help resolving the issue.
C) A consumer agency is not appropriate because this is an ethical matter.
D) The nurse should act on behalf of the client, and the best way to do that is by taking the issue to the hospital ethics committee, not to the healthcare provider.
Page Ref: 2737
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.13. Acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 44.5. Summarize strategies to enhance ethical decisions in practice.
MNL LO: Analyze the concept of ethics and its application to nursing care.

7) A 22-year-old client with Down syndrome and an intellectual disability is under the legal care of the parents. The client needs medical treatment for aspiration pneumonia, but the parents are declining care because they have heard that aspiration pneumonia is often fatal in clients with chronic health conditions. In addition to ethics and advocacy, which other nursing concept must the nurse factor into care decisions made in this case?
A) Informatics
B) Development
C) Mood and affect
D) Spirituality
Answer: B
Explanation: A) Informatics does not play a role in this case.
B) Down syndrome causes intellectual disability, so the client's developmental stage needs to be taken into consideration when providing care, especially related to client teaching and advocating for the client whose rights appear to be in jeopardy.
C) Mood and affect do not play a role in this case.
D) Spirituality does not play a role in this case.
Page Ref: 2732
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Planning
Learning Outcome: 44.2. Outline the relationship between ethics and other concepts.
MNL LO: Analyze the concept of ethics and its application to nursing care.

8) The nurse administers morphine to a client after surgery to help manage pain even though morphine has a risk of creating dependence and addiction. Which ethical principle does the nurse apply in this situation when planning care?
A) Veracity
B) Justice
C) Autonomy
D) Beneficence
Answer: D
Explanation: A) Veracity is the principle of always telling the truth.
B) Justice means treating all clients fairly.
C) Autonomy is the right to self-determination.
D) Beneficence requires that the actions one takes should promote good. This includes giving treatments that have some risks when the nurse and others involved in client care have determined that the benefits outweigh the risks.
Page Ref: 2735
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 44.4. Analyze the principles of ethical decision making.
MNL LO: Analyze the concept of ethics and its application to nursing care.

9) Every year, the nurse attends a nursing conference and takes several continuing education courses to help maintain licensure. Which section of the ICN Code of Ethics does this uphold?
A) Nurses and people
B) Nurses and practice
C) Nurses and the profession
D) Nurses and co-workers
Answer: B
Explanation: A) The nurses and people section of the ICN Code of Ethics does not address continuing education for nurses.
B) The nurses and practice section of the ICN Code of Ethics states that nurses carry the professional responsibility and accountability for nursing practice and for maintaining competence by continual learning.
C) The nurses and profession section of the ICN Code of Ethics does not address continuing education for nurses.
D) The nurses and co-workers section of the ICN Code of Ethics does not address continuing education for nurses.
Page Ref: 2734
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation

Learning Outcome: 44.4. Differentiate the various codes of ethics used in nursing.
MNL LO: Analyze the concept of ethics and its application to nursing care.

Exemplar 44.A Morality

1) A client, learning that her baby has died in utero, is planning to carry the baby until natural delivery because abortion is against her religion. Which behavior is the client demonstrating based on this data?
A) Fear of retribution
B) Morals
C) A healthy decision
D) Sound judgment
Answer: B
Explanation: A) The nurse has no way of knowing if the client is in fear of retribution.
B) Religion and morals can at times be interrelated within healthcare. The client wants to maintain the baby until natural delivery occurs because having an abortion would be against her religion. The client is demonstrating her morals.
C) The client may or may not be demonstrating a healthy decision.
D) The client may or may not be demonstrating sound judgment.
Page Ref: 2740
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.2. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; Collaborate and work cooperatively with others; Resolve conflicts; Respond to moral and ethical challenges. | Nursing Process: Evaluation
Learning Outcome: 44.A. Analyze morality as it relates to ethics. Explain the development of morality.
MNL LO: Analyze the concept of ethics and its application to nursing care.

2) Which situation indicates a conflict in morality?

A) The nurse provides a terminally ill client a meal that includes foods that should be avoided but were requested.

B) The nurse provides the mother of a dying neonate a cup of coffee in the intensive care unit.

C) The nurse provides over-the-counter pain relievers to the daughter of a client because of a headache.

D) The nurse purchases the daily newspaper for a client who does not have any money but will when the partner comes to visit.

Answer: A

Explanation: A) Morality refers to issues that are either right or wrong. In the situations provided, the nurse who provides a terminally ill client a meal with food that should be avoided but requested would demonstrate a conflict with morality. The nurse is going against the "right" decision, which would be to not provide the client with the foods; however, the client is terminally ill and is requesting foods that the client enjoys.

B) Giving the mother of a dying neonate a cup of coffee is not a conflict in morality.

C) Providing an over-the-counter medication to someone with a headache does not cause a conflict in morality.

D) Buying a newspaper for a client until the client has the money is not a conflict in morality.

Page Ref: 2735, 2740

Cognitive Level: Analyzing

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.C.13. Acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; Collaborate and work cooperatively with others; Resolve conflicts; Respond to moral and ethical challenges. | Nursing Process: Evaluation

Learning Outcome: 44.A. Analyze morality as it relates to ethics. Summarize moral principles.

MNL LO: Analyze the concept of ethics and its application to nursing care.

3) The family of a terminally ill client requests that the client not be informed of the diagnosis. Which moral principle does the request violate?

A) Justice
B) Veracity
C) Beneficence
D) Nonmaleficence

Answer: B

Explanation: A) Justice refers to fairness.
B) Veracity is the duty to tell the truth. The family of a terminally ill client is requesting that the diagnosis be withheld from the client, which would violate the principle of veracity.
C) Beneficence is the duty to "do good."
D) Nonmaleficence is the duty to do no harm.

Page Ref: 2739
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.C.13. Acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; Collaborate and work cooperatively with others; Resolve conflicts; Respond to moral and ethical challenges. | Nursing Process: Assessment
Learning Outcome: 44.A. Analyze morality as it relates to ethics. Summarize moral principles.
MNL LO: Analyze the concept of ethics and its application to nursing care.

4) A client who was raped tells the nurse that she is planning to have an abortion because she cannot raise a child who was conceived this way; however, abortion is against her religion. Which action by the nurse is the most appropriate?

A) Remind the client that abortion is killing and that's why it is against her religion

B) Ask the client what she needs to support her decision.

C) Provide information on giving up children for adoption.

D) Suggest she talk with her clergy.

Answer: B

Explanation: A) The nurse should not remind the client that abortion is killing because this would not support the client's resolution of her moral dilemma.

B) The client's decision is to have an abortion even though it is against her religion. The best thing for the nurse to do is to ask the client what she needs to support her decision.

C) The nurse should not provide information about adoption because the client is not planning on carrying the child to term.

D) The nurse should not suggest she talk with clergy because the client did not ask to do so.

Page Ref: 2741

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: I.C.13. Acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Relationship Centered Care: Share responsibility responsibly; Collaborate and work cooperatively with others; Resolve conflicts; Respond to moral and ethical challenges. | Nursing Process: Implementation

Learning Outcome: 44.A. Analyze morality as it relates to ethics. Summarize moral principles.

MNL LO: Analyze the concept of ethics and its application to nursing care.

5) A nursing instructor is discussing moral principles with a group of students. Which comment made by a student nurse indicates the need for further instruction?
A) "A client choosing not to have a needed blood transfusion is an example of autonomy."
B) "An example of veracity would be if a client asks the nurse if they are going to die and the nurse feels obligated to explain to the client that they are dying."
C) "If a client asks the nurse to please come right back, and the nurse tells the client they will be back in just a couple of minutes, and the nurse returns, then that would be an example of fidelity."
D) "A home health nurse carefully planning their day to assure each client gets an adequate amount of time is an example of beneficence."
Answer: D
Explanation: A) Autonomy refers to the right to make one's own decisions.
B) Veracity refers to telling the truth.
C) Fidelity means to be faithful to agreements and promises.
D) Justice is often referred to as fairness, which would be demonstrated by the nurse assuring that each client gets an adequate amount of time with the nurse. Beneficence refers to the fact that nurses are obligated to do good.
Page Ref: 2739
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Evaluation
Learning Outcome: 44.A. Analyze morality as it relates to ethics. Summarize moral principles.
MNL LO: Analyze the concept of ethics and its application to nursing care.

6) The nurse is admitting a client to the medical unit who was brought to the emergency department by a neighbor. The client states, "I ran out of my medication last week. I don't have any family or close friends to help me." Upon assessment, the nurse notes the following findings: oxygen saturation of 93% on room air, breath sounds reveal crackles bilateral bases, P 110 bpm, R 22 breaths per min, BP 110/60 mmHg. Which problem is the priority for this client?
A) Social isolation
B) Potential for low self-esteem
C) Nonadherence
D) Problem with family processes
Answer: A
Explanation: A) Social isolation led to the client's current medical manifestations. The priority problem would be social isolation.
B) There is no evidence that the client has low self-esteem.
C) The client was nonadherent, but this is not the priority problem.
D) There is no evidence that the client has a problem with family processes.
Page Ref: 2740
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Personal and Professional Development: Demonstrate respect for all persons and for human dignity, equality, and justice. | Nursing Process: Diagnosis
Learning Outcome: 44.A. Analyze morality as it relates to ethics. Summarize moral principles.
MNL LO: Analyze the concept of ethics and its application to nursing care.

7) The nurse is caring for a client who has chosen to discontinue hemodialysis. The client's family, however, is not supportive of the decision. The nurse who uses the theory of principles-based reasoning would make which statement regarding the current situation?
A) "The client understands the decision and the advanced stage of the disease. If the client quits treatment, the client will die."
B) "I need to try to help the family understand the client's decision so they can work through this situation together."
C) "This client is of sound mind and is capable of making independent decisions regarding healthcare. It really is the client's decision to make."
D) "This client's health is so deteriorated that the treatment is not saving the client's life. It is prolonging the ultimate outcome, which is death."
Answer: C
Explanation: A) The client's understanding of his decision and its consequences does not address the client's right to make a decision autonomously.
B) Trying to help the family understand the client's decision is an example of a caring-based theory in practice. Caring theories, or relationship theories, stress courage, generosity, commitment, and the need to nurture and maintain relationships. Caring theories promote the common good or the welfare of the group.
C) Principles-based theories stress individual rights, such as autonomy. The client has the ability to make the decision, and it is his right to autonomy to do that.
D) Considering the client's condition and the outcome of treatment is an example of consequence-based reasoning, in which the nurse looks at the outcomes of the client's decision.
Page Ref: 2738-2739
Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.13. Acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 44.A. Analyze morality as it relates to ethics. Explain how moral theories can be used as a framework for examining ethical dilemmas.
MNL LO: Analyze the concept of ethics and its application to nursing care.

8) The nurse on a committee to determine the funding that each part of the hospital receives would be most concerned with which moral theory?
A) Consequence-based theory
B) Principles-based theory
C) Relationship-based theory
D) Legal-based theory
Answer: A
Explanation: A) Consequence-based theories tend to view a moral act as one that brings about the most good and the least harm to the greatest number of people. This moral theory would be a driving force when allocating funding in a hospital.
B) Principles-based theory determines morality based on an impartial, objective principle and is more concerned with the individual than the group.
C) Relationship-based theories judge actions according to a perspective of caring and responsibility, which is less likely to be needed when determining funding.
D) Legal-based theory is not a moral theory.
Page Ref: 2738-2739
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 44.A. Analyze morality as it relates to ethics. List three types of moral theories.
MNL LO: Analyze the concept of ethics and its application to nursing care.

Exemplar 44.B Ethical Dilemmas

1) A hospice nurse is working closely with a client who, on several occasions, has asked about guidance and support in ending life. The nurse recognizes which in regard to making ethical and moral decisions in this circumstance?
A) Euthanasia has legal implications along with moral and ethical ones.
B) Passive euthanasia is an easy decision to arrive at.
C) Active euthanasia is supported in the Code for Nurses.
D) Assisted suicide is illegal in all states.
Answer: A
Explanation: A) Determining whether an action is legal is only one aspect of deciding whether it is ethical. Legality and morality are not one and the same. The nurse must know and follow the legal statutes of the profession and boundaries within the state before making any decision.
B) Passive euthanasia involves the withdrawal of extraordinary means of life support and is never an easy decision.
C) Active euthanasia and assisted suicide are in violation of the Code for Nurses, according to the position statement by the ANA (2013).
D) Some states and countries have laws permitting assisted suicide for clients who are severely ill, are near death, and wish to commit suicide.
Page Ref: 2747
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.13. Acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation

Learning Outcome: 44.B. Analyze dilemmas related to ethics. Analyze the challenges and dilemmas patients and their families face when managing end-of-life care choices, advance directives, euthanasia, and the withdrawal of life support.
MNL LO: Analyze the concept of ethics and its application to nursing care.

2) The nurse is talking with a parent who decides to decline treatment for a 3-year-old client whose cancer has metastasized. There is a conflict between the parents and the rest of the family regarding the withdrawal of care from the child. Which information should the nurse consider when determining the appropriate action for this client?
A) The beliefs of the child
B) The values of the parents
C) The age of the child
D) The values of the rest of the family
Answer: B
Explanation: A) The child is too young to have values and beliefs.
B) When confronted with a conflict regarding care, one of the first actions by the nurse is to consider the values and beliefs of the parents who are making the decision.
C) The age of the child is not a relevant factor in the decision making if the child is under 18 years.
D) The nurse is respectful with the rest of the family but should consider the parents' decision only.
Page Ref: 2751
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.2. Respect and encourage individual expression of patient values, preferences, and expressed needs. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Planning
Learning Outcome: 44.B. Analyze dilemmas related to ethics. Differentiate considerations related to ethical dilemmas for patients across the lifespan.
MNL LO: Analyze the concept of ethics and its application to nursing care.

3) A client comes to the clinic and is found to have a sexually transmitted infection (STI). The client states to the nurse, "Promise you won't tell anyone about my condition." According to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which action must the nurse take?
A) Honor the client's wishes.
B) Respect the client's privacy and confidentiality.
C) Communicate only necessary information.
D) Not disclose any information to anyone.
Answer: C
Explanation: A) Nurses should not make promises to keep necessary information private.
B) Clients must be able to trust that their information is secure and will only be shared with appropriate entities.
C) HIPAA includes standards that protect the confidentiality, integrity, and availability of data as well as standards that define appropriate disclosures of identifiable health information and client rights protection.
D) Nurses are entrusted with sensitive information, which at times must be revealed to other healthcare personnel in order to provide appropriate healthcare. In this case, the nurse may be required to report information to the state health department.
Page Ref: 2749
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.C.13. Acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Codes of ethics, regulatory and professional standards; Ethical decision-making models; Scope of practice considerations; Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Implementation
Learning Outcome: 44.B. Analyze dilemmas related to ethics. Critique the bioethical dilemmas that may arise during the care of patients and families.
MNL LO: Analyze the concept of ethics and its application to nursing care.

4) When faced with ethical dilemmas, which elements of risk management can assist nurses in decision making? **Select all that apply.**
A) Education
B) Peer support and consultation
C) Resource accumulation
D) Righteousness
E) Financial support
Answer: A, B, C
Explanation: A) In addition to the ANA code of conduct in ethical situations, education and didactic training represent another source for developing primary risk-management skills.
B) A practitioner's professional network, consisting of peers, supervisors, and colleagues, can be a significant resource for primary prevention of ethical challenges.
C) Resource accumulation involves acquiring the requisite resources and skills prior to the occurrence of a dilemma.
D) Righteousness is not an element of risk management.
E) Financial support is not an element of risk management.
Page Ref: p. 2751
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Planning
Learning Outcome: 44.B. Analyze dilemmas related to ethics. Propose solutions to ethical dilemmas based on an individual's problem and ethical principles.
MNL LO: Analyze the concept of ethics and its application to nursing care.

5) Staff at the hospital have decided to strike in order to try to improve working conditions. Which ethical issues would a nurse working in the hospital have to consider when deciding whether or not to honor the picket line? **Select all that apply.**
A) The need to support coworkers in their efforts to improve working conditions
B) The need to ensure that clients receive care and are not abandoned
C) The desire to take some time off
D) Loyalty to the nurse's employer
E) The need for higher pay
Answer: A, B, D
Explanation: A) Strikers may be concerned about the need to support coworkers in their efforts to improve working conditions.
B) Strikers may be concerned about client care as it is related to adequate staffing. Strikes may adversely affect client care and outcomes.
C) The desire to take time off is not an ethical issue.
D) Nurses may feel allegiance to a hospital where they have worked for years.
E) The need for higher pay is not an ethical issue.
Page Ref: 2745
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.13. Acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Planning

Learning Outcome: 44.B. Analyze dilemmas related to ethics. Analyze conflicts among nursing loyalties and obligations to patients, families, the multiprofessional team, and outside organizations.
MNL LO: Analyze the concept of ethics and its application to nursing care.

6) A pregnant client with a history of drug use refuses testing for human immunodeficiency virus (HIV), despite the recommendation of the nurse-midwife. Which actions by the nurse are appropriate in this situation? **Select all that apply.**
A) Refuse to treat the client.
B) Do the testing anyway.
C) Re-emphasize the importance of HIV testing.
D) Offer counseling.
E) Throughout the pregnancy, encourage the client to reconsider the decision not to be tested.
Answer: C, D, E
Explanation: A) Refusing to treat the client is against the ANA position statement on risk and responsibility in nursing.
B) Doing the test anyway goes against the client's right to autonomy.
C) The nurse should emphasize the importance of HIV testing and encourage her to receive the test.
D) Offering counseling would also be appropriate.
E) Refusing HIV testing is legal and is not mandatory for obtaining care. However, if the mother-to-be is HIV-positive, the test will help her protect her health and the health of her child by obtaining appropriate treatment.
Page Ref: 2745
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.13. Acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation

Learning Outcome: 44.B. Analyze dilemmas related to ethics. Critique the bioethical dilemmas that may arise during the care of patients and families.
MNL LO: Analyze the concept of ethics and its application to nursing care.

7) A hospice nurse is working with a client who has ovarian cancer. The client is concerned that her two daughters are at an increased risk for cancer and asks for the nurse's help. Which actions by the nurse are appropriate? **Select all that apply.**
A) Provide the family with information on hereditary cancer risks.
B) Assure the client that ovarian cancer is not hereditary.
C) Offer to refer the daughters to a genetic counselor.
D) Arrange for the client to have genetic testing.
E) Tell the client that her additional worrying is too stressful.
Answer: A, C, D
Explanation: A) A nurse's role as educator is crucial to ethical practice.
B) Inaccurate reassurance does not respect client rights.
C) Providing appropriate alternatives addresses the client's concerns.
D) Providing appropriate options addresses the client's concerns.
E) Avoidance does not respect client rights.
Page Ref: 2746
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: QSEN Competencies: I.C.2. Respect and encourage individual expression of patient values, preferences, and expressed needs. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 44.B. Analyze dilemmas related to ethics. Explore the nurse's role in supporting patients' rights to information and counseling when making genetic testing decisions.
MNL LO: Analyze the concept of ethics and its application to nursing care.

8) For which reasons would the nurse withhold food and fluids from a client? **Select all that apply.**
A) A competent and informed client refuses them.
B) A son decides that it is his father's time to die.
C) It is determined to be more harmful to administer them than to withhold them.
D) A schizophrenic client believes that they are being poisoned.
E) The nurse thinks that the client is in too much pain.
Answer: A, C
Explanation: A) The autonomy of a competent and informed client must be respected.
B) Family members cannot overrule client choices.
C) Forcing an individual with terminal illness to eat, or starting artificial nutrition, will often make the client feel bloated, feel nauseated, and/or develop diarrhea.
D) Clients must be capable of making informed choices.
E) The nurse's opinion about the client's pain status is not a justification for withholding nourishment.
Page Ref: 2748
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards; ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 44.B. Analyze dilemmas related to ethics. Analyze the challenges and dilemmas patients and their families face when managing end-of-life care choices, advance directives, euthanasia, and the withdrawal of life support.
MNL LO: Analyze the concept of ethics and its application to nursing care.

9) A client with acquired immune deficiency syndrome (AIDS) is admitted to the acute care floor. According to a 2015 American Nurses Association (ANA) position statement, which stance addressing this bioethical issue is appropriate?
A) The nurse is morally obligated to care for the client unless the risk exceeds responsibility.
B) The nurse has the responsibility to ensure the client gets adequate medical care.
C) The client has the right to choose not to disclose their condition to staff.
D) The client is morally bound to disclose every aspect of their condition to staff.
Answer: A
Explanation: A) According to a 2015 ANA position statement, the nurse cannot set aside the moral obligation to care for the client infected with human immunodeficiency virus (HIV) unless the risk exceeds the responsibility.
B) The nurse does not have the responsibility to ensure the client gets adequate medical care.
C) The condition is reportable and therefore the client has to disclose the condition to the staff.
D) The client is not morally bound to disclose every aspect of their condition to the staff.
Page Ref: 2745
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 44.B. Analyze dilemmas related to ethics. Critique the bioethical dilemmas that may arise during the care of patients and families.
MNL LO: Analyze the concept of ethics and its application to nursing care.

10) An adolescent client diagnosed with leukemia decides to stop chemotherapy treatments. The parents of the client, however, want the healthcare team to continue all treatments as necessary. Which action by the nurse is appropriate when providing care to this client and family?
A) Helping the family by providing information and allowing them to voice concerns
B) Confronting the parents and telling them not to be "selfish" in their child's time of need
C) Calling the authorities immediately
D) Obtaining a court order to determine the client legally able to make their own decisions
Answer: A
Explanation: A) Parents have the authority to make healthcare decisions for their children. Dilemmas arise when parents and children do not agree on whether or not to go forward with a recommended treatment. In most cases, the nurse and other members of the healthcare team who have developed a therapeutic alliance with the child and family may be able to help the family come to a joint decision by providing additional information and opportunity to discuss their concerns with each other calmly and openly. In some cases, however, the healthcare team may need to seek guidance from the agency's ethics committee.
B) The parents are not to be confronted or called selfish.
C) The authorities are not to be contacted.
D) A court order is not needed.
Page Ref: 2751
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.2. Respect and encourage individual expression of patient values, preferences, and expressed needs. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Apply advocacy skills and ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 44.B. Analyze dilemmas related to ethics. Differentiate considerations related to ethical dilemmas for patients across the lifespan.
MNL LO: Analyze the concept of ethics and its application to nursing care.

Exemplar 44.C Patient Rights

1) Which rights does a client have when receiving care within a healthcare system? **Select all that apply.**
A) Clients have the right to be given information only in English.
B) Clients have the right to refuse care.
C) Clients have the right to know when something goes wrong with their care.
D) Clients have the right to care that is free from discrimination.
E) Clients have the right to know the titles, but not necessarily the names, of their caregivers.
Answer: B, C, D
Explanation: A) Clients have the right to get important information about their care in their preferred language.
B) Clients may reject as well as accept care.
C) Clients should be informed of problems with their care.
D) Clients should be treated without discrimination.
E) Clients have the right to know the names of the caregivers who treat them.
Page Ref: 2753
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation

Learning Outcome: 44.C.1. Analyze patient rights as they relate to ethics. Examine the rights of patients in the healthcare system.
MNL LO: Analyze the concept of ethics and its application to nursing care.

2) A nurse is providing hospice care for an older adult client. The nurse is approached by the client's adult child. The adult child believes that the other parent, who is in a nursing home, is being neglected. Which suggestions can the nurse offer in this situation? **Select all that apply.**
A) Contact the client advocate at the nursing facility.
B) Contact the local newspaper.
C) Encourage the adult child to immediately place the other parent in a different facility.
D) Contact the consumer protection agency.
E) Report suspicions to the licensing agency.
Answer: A, E
Explanation: A) Many large agencies have client advocates who can help ensure that client rights are maintained.
B) It is important to consider institutionalized remedies before taking extraordinary action.
C) Transferring clients in long-term facilities is often very difficult.
D) The consumer protection agency is not usually involved in nursing home issues.
E) Nursing homes, homes for the aged, and licensed facilities for the disabled are regulated at the state level, and violations committed by these agencies may be reported for investigation.
Page Ref: 2754
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation

Learning Outcome: 44.C. Analyze patient rights as they relate to ethics. Analyze support systems that exist for patients who feel that their rights have been violated by a healthcare agency or provider.
MNL LO: Analyze the concept of ethics and its application to nursing care.

3) A nurse educator is explaining the idea of healthcare as a partnership between provider and client. Which client responsibilities have been included in some hospital's client bill of rights? **Select all that apply.**
A) Involving your family in your healthcare decisions
B) Reporting accurate and complete information about your health to your healthcare team
C) Answering questions asked by your healthcare team
D) Immediately paying all expenses not covered by insurance
E) Accepting the consequences if you fail to comply with instructions given to you
Answer: B, C, E
Explanation: A) It is not essential for clients to involve their family members in healthcare decisions.
B) Clients have the responsibility to provide complete and accurate information about their symptoms, history, and status to their healthcare team.
C) Clients have the responsibility to answer questions asked by the healthcare team.
D) Accepting financial responsibility for treatment does not require immediate payment.
E) Clients must understand that noncompliance with treatment recommendations may result in poor outcomes.
Page Ref: 2754
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 44.C. Analyze patient rights as they relate to ethics. Compare the contents of different documents or laws that address patient rights.
MNL LO: Analyze the concept of ethics and its application to nursing care.

4) A client says, "I really don't like the nurse on first shift. I was treated badly." Which action should the nurse take as an advocate for this client?
A) Call the agency client advocacy department.
B) Confront the nurse when they come to work.
C) Tell the client they have the right to switch nurses.
D) Call the local authorities.
Answer: A
Explanation: A) Individual clients who feel their rights have been violated or are endangered have a number of options. Many hospitals and large provider agencies have client advocates who can help clients navigate the system and intervene to ensure that their rights are maintained. Many states have an office designated by the governor or secretary of health to assist clients with issues related to patient rights in long-term care. The state's department of health may also be able to help.
B) The nurse should not be confronted.
C) The nurse needs to do more than tell the client about having a right to switch nurses.
D) Local authorities do not need to be contacted.
Page Ref: 2754
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation

Learning Outcome: 44.C. Analyze patient rights as they relate to ethics. Analyze support systems that exist for patients who feel that their rights have been violated by a healthcare agency or provider.
MNL LO: Analyze the concept of ethics and its application to nursing care.

5) The nurse performing an admission assessment on a client must inform the client of client rights and responsibilities. Which client rights are considered standard by many healthcare agencies? **Select all that apply.**
A) You have a right to be informed about the care you receive.
B) You have the right to safe care.
C) You have the right to be treated with courtesy and respect.
D) You have the right to be listened to.
E) You have the right to be appointed a personal advocate by the healthcare provider.
Answer: A, B, C, D
Explanation: A) The Joint Commission's Speak Up program is dedicated to patient rights and contains: You have the right to be informed about the care you will receive.
B) The Joint Commission's Speak Up program is dedicated to patient rights and contains: You have the right to safe care.
C) The Joint Commission's Speak Up program is dedicated to patient rights and contains: You have the right to be treated with courtesy and respect.
D) The Joint Commission's Speak Up program is dedicated to patient rights and contains: You have the right to be listened to.
E) The Joint Commission's Speak Up program is dedicated to patient rights and contains: You have the right to have a personal representative of your choice, not to have one appointed to you by the healthcare provider.
Page Ref: 2753
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 44.C. Analyze patient rights as they relate to ethics. Examine the rights of patients in the healthcare system.
MNL LO: Analyze the concept of ethics and its application to nursing care.

6) The nurse on the mother-baby unit is confronted by a client who states, "I know my rights and you have to do what I tell you!" Which response by the nurse is most appropriate?
A) "I don't mind doing anything within reason, but you have a responsibility to be considerate to the staff as well."
B) "That statement is not included in your client rights; don't yell at me."
C) "Why do you feel angry . . . did I do something you did not like?"
D) "Do you want me to take the baby to the nursery so you can calm down?"
Answer: A
Explanation: A) Most hospitals now publish lists of client responsibilities, emphasizing that healthcare is a partnership between the client and caregivers, that other clients have a right to be comfortable too, and that there are consequences if clients don't comply with treatment plans, cooperate with the healthcare team, or be considerate of the staff and other clients.
B) The nurse should not respond to the client with anger.
C) The nurse should not ask the client why they are angry.
D) The nurse should not threaten the client by taking the baby.
Page Ref: 2754-2755
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 44.C. Analyze patient rights as they relate to ethics. Compare the contents of different documents or laws that address patient rights.
MNL LO: Analyze the concept of ethics and its application to nursing care.

7) The nurse is caring for an older adult client who will undergo surgery in the morning. While assessing the client, the nurse discovers that the client does not have an adequate understanding of the procedure. The nurse discusses the situation with the charge nurse to determine the best course. Which is the reason for the nurse to take action in this situation?
A) The client is very old and has multiple health problems.
B) The family needs to agree to surgery.
C) The nurse witnessed the consent.
D) The client has a right to informed consent.
Answer: D
Explanation: A) The client's age is not the reason for the nurse taking action.
B) The family does not make the decision regarding surgery unless the client has been declared incompetent by the court.
C) The nurse would want to have the surgery explained for the client's sake, not because the nurse signed the form.
D) Sometimes older adults forget and get confused. However, the nurse should notify the surgeon because the client has the right to informed consent.
Page Ref: 2753
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation

Learning Outcome: 44.C. Analyze patient rights as they relate to ethics. Differentiate considerations related to patient rights across the lifespan.
MNL LO: Analyze the concept of ethics and its application to nursing care.

8) A pregnant woman has been rushed to the operating room for an emergency cesarean section. The physician explained the procedure to the parents, and he asked the father to wait in the waiting room until the procedure is complete. The mother asked if the father could be in the room to see the baby delivered and to help make decisions about the baby's care, but the physician explained that because of the emergency situation, that wouldn't be allowed. In this situation, which client right was violated?
A) The right to know when something goes wrong with care.
B) The right to be treated with courtesy and respect.
C) The right to have a personal representative.
D) The right to be listened to.
Answer: C
Explanation: A) The father will likely still be informed if something goes wrong with the procedure even if he can't be present in the room.
B) There is no indication that they weren't treated with courtesy and respect.
C) Because the father was not allowed to be present in the operating room, the clients (both the mother and baby) were denied the right to have a personal representative with them during their care.
D) Even though he denied the request, the physician did listen to the parents.
Page Ref: 2753
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.C.13. Acknowledge the tension that may exist between patient rights and the organizational responsibility for professional, ethical care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Assessment

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Learning Outcome: 44.C. Analyze patient rights as they relate to ethics. Examine the rights of patients in the healthcare system.
MNL LO: Analyze the concept of ethics and its application to nursing care.

***Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e* (Pearson)**

Module 45 Evidence-Based Practice

The Concept of Evidence-Based Practice

1) The nurse is caring for a client who requires extensive wound care. The client has consented to participate in a nursing research study regarding the wound care. Which client statement indicates understanding of the research goal?
A) "This research will not influence my care."
B) "Nursing care is based solely on research."
C) "I will be paid to participate in the research project."
D) "I will be helping to improve patient outcomes."
Answer: D
Explanation: A) Participation in this research project will probably change the normal routine of the client's care.
B) Nursing care is based on intuition and the experience of the nurse as well as research and evidence-based practice.
C) Clients do not receive pay for participating in research.
D) Translational research is a systematic approach of converting research knowledge into applications of healthcare for improved client outcomes.
Page Ref: 2761
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.C.3. Value the concept of EBP as integral to determining best clinical practice. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 45.2. Outline the relationship between evidence-based practice and other concepts.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

2) A nurse researcher is preparing to give a presentation about evidence-based practice (EBP) to a group of nursing students. Which statements would be appropriate for the nurse researcher to include in this presentation?
A) "EBP focuses solely on research-based evidence, and it assumes that best practices for nursing care exist independent of client preferences."
B) "EBP involves integrating research evidence, the nurse's own clinical expertise, and client values and preferences."
C) "EBP is sometimes also referred to as translational research."
D) "EBP is typically only associated with complex nursing tasks, such as preparing clients for surgery and monitoring for adverse effects."
Answer: B
Explanation: A) EBP does not focus solely on research-based evidence, nor does it assume that best practices for care exist independent of client preferences.
B) EBP involves integrating research evidence, the nurse's own clinical expertise, and client values and preferences.
C) Translational research is a systematic approach of converting research knowledge into applications of healthcare for improved patient outcomes.
D) EBP informs nursing procedures of all types, from simple to complex.
Page Ref: 2759
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.C.3. Value the concept of EBP as integral to determining best clinical practice. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery.| NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

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Learning Outcome: 45.1. Summarize the evolution of evidence-based practice.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

3) The nurse working in a community hospital is caring for a client who does not seem to be responding well to the current plan of care that has been implemented by the nursing team. Given this information, which actions by the nurse are appropriate? **Select all that apply.**
A) Accessing research journals for evidence that would support a change in the plan of care
B) Proposing a nursing research project to the unit manager
C) Networking online with other nurses who are giving similar care
D) Asking the doctor for a new nursing approach to care
E) Trying a different approach to care even though it breaches hospital policy
Answer: A, C
Explanation: A) A nurse in a community hospital may not have immediate access to the latest in nursing research. In order to improve care, this nurse might access research journals to determine whether there is any evidence that would support changes in the client's nursing care.
B) Proposing a research project is an excellent way to improve client care, but this nurse needs a more immediate solution to the client's problems.
C) A nurse in a community hospital may not have immediate access to the latest in nursing research. In order to improve care, this nurse might network with other nurses to determine whether there is any evidence that would support changes in the client's nursing care.
D) The physician is not involved in solving nursing problems.
E) The nurse should not breach hospital policy even if the client were to benefit.
Page Ref: 2760
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.B.6. Participate in structuring the work environment to facilitate integration of new evidence into standards of practice. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Retrieve research findings and other sources of information; critique research to judge its value and usefulness; evaluate the strength of evidence for application of research findings to clinical practice. | Nursing Process: Implementation
Learning Outcome: 45.4. Analyze the four steps of developing evidence-based practice.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

4) A client in the clinic is being asked to participate in a research study. The client asks why a nursing research study is necessary given that research on this subject has already been published by the American Medical Association (AMA). Which response should the nurse offer in reply to the client's question?
A) "This study is useful because it supports the medical profession."
B) "This study is useful because it validates nursing through medical research."
C) "This study is useful because it supports products used in nursing care."
D) "This study is useful because it is used to improve patient care."
Answer: D
Explanation: A) Nursing research does not seek to support the medical profession but the nursing profession.
B) Nursing research validates nursing, not medicine.
C) Nursing research is not established to support products but to improve client care.
D) Nursing research seeks answers to questions that ultimately improve patient care.
Page Ref: 2762
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.C.3. Value the concept of EBP as integral to determining best clinical practice. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 45.2. Outline the relationship between evidence-based practice and other concepts.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

5) The nurse manager for a medical-surgical nursing unit is talking to a group of nursing students. The nurse manager is explaining the types of nursing research studies that are conducted on the unit. Which statement by the students indicates understanding of the nature of nursing research?
A) "Nursing research does not include nursing education or nursing leadership."
B) "Nursing research does not include the study of nurses themselves."
C) "Nursing research impacts nursing by adding knowledge and changing nursing practice."
D) "Nursing research is used to enhance medical treatment."
Answer: C
Explanation: A) Research includes the educational aspects of nursing and nursing leadership.
B) Nursing research includes the study of nurses themselves.
C) Nursing research impacts the profession by adding knowledge and changing nursing practice.
D) Nursing research does not enhance medical treatment but enhances nursing care.
Page Ref: 2762
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.C.3. Value the concept of EBP as integral to determining best clinical practice. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 45.3. Summarize the fundamentals of research methodology.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

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6) A nursing preceptor is working with a novice nurse on a medical-surgical unit. During client care, the novice nurse shares an evidence-based wound care technique that is being used with much success. Which action is being encouraged when the novice nurse shares this information with the preceptor?
A) Use of trial and error to gain knowledge
B) Use of existing unit modes of care
C) Use of new knowledge gained through research
D) Use of medical knowledge to perform care
Answer: C
Explanation: A) The novice nurse is not using trial and error to gain knowledge.
B) The novice nurse is not encouraging the preceptor to use existing modes of care.
C) The novice nurse is sharing evidence learned through research that may enhance client care.
D) The novice nurse is not using medical knowledge to perform care.
Page Ref: 2762
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Defining what is evidence-based practice. | Nursing Process: Implementation
Learning Outcome: 45.5. Contrast differences between implementing individual and organizational evidence-based practice.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

7) The head nurse in a pediatrician's office is interested in incorporating more aspects of evidence-based practice (EBP) into the facility's regular nursing procedures and protocols. Which resource would be most useful in helping the nurse achieve this goal?
A) An American Nurses Association (ANA) report about best practices for reducing the incidence of pressure injuries
B) Documentation from the Centers for Disease Control and Prevention regarding recommended vaccinations for individuals who plan to travel abroad
C) A report from the National Institutes of Health (NIH) describing a new sickle cell screening protocol
D) A journal article discussing the perceived versus actual effectiveness of various approaches to smoking cessation
Answer: C
Explanation: A) A report about pressure injuries would be appropriate for older clients.
B) Information about vaccinations for travel abroad would be appropriate for an older population of clients.
C) Of the resources listed, the NIH report about a new sickle cell screening protocol would be of greatest use to a nurse in a pediatrician's office.
D) Information about smoking cessation would be more appropriate for a population of older clients.
Page Ref: 2762
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Defining what is evidence-based practice. | Nursing Process: Implementation

Learning Outcome: 45.5. Contrast differences between implementing individual and organizational evidence-based practice.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

8) The nurse is applying evidence related to a clinical question to enhance a client's care. Which questions will the nurse ask to evaluate if the evidence is valid and applicable? **Select all that apply.**

A) Were there any unintended results?

B) Are there any areas that need improvement?

C) Did the evidence reduce the cost of care?

D) Did the evidence yield the intended result?

E) Did the evidence reduce the client's length of stay?

Answer: A, B, D

Explanation: A) Once the evidence has been applied, the nurse should ask if there are any unintended results.

B) Once the evidence has been applied, the nurse should ask if there are any areas that need improvement.

C) Reducing the cost of care is not a question that is asked when evaluating the applicability and validity of evidence.

D) Once the evidence has been applied, the nurser should ask if the evidence yielded the intended result.

E) Reducing the client's length of stay is not a question that is asked when evaluating the applicability and validity of evidence.

Page Ref: 2768

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Defining what is evidence-based practice. | Nursing Process: Implementation

Learning Outcome: 45.4. Analyze the four steps of developing evidence-based practice.

MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

9) The research nurse is planning a study that will require additional assistance to complete the analysis. Which action should the nurse take to obtain resources to help fund the study?
A) Ask the hospital to fund the research
B) Ask a local school of nursing for funding
C) Network with physicians to help with the funding
D) Apply for a research grant from a nursing organization
Answer: D
Explanation: A) Funding of research can be obtained from a variety of resources; however, the hospital is not identified as one source.
B) Schools of nursing are not identified as sources of funding for research.
C) Physicians are not usually asked to fund nursing research projects.
D) Funding from many sources is available to nurses who are interested in doing research to advance nursing science and generate evidence that supports improved client care. This funding ranges from small research grants from local professional nursing chapters to larger grants awarded by state or national nursing organization foundations.
Page Ref: 2762
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.C.3. Value the concept of EBP as integral to determining best clinical practice. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 45.3. Summarize the fundamentals of research methodology.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

10) The nurse is working with a client who has agreed to participate in a research study. Which actions would constitute a violation of the client's right to full disclosure? **Select all that apply.**
A) Giving the client false information about his or her participation in the study
B) Telling a mutual friend about the client's involvement in the study
C) Withholding information about the study from the client
D) Providing the client's name as a participant in the study
E) Suggesting that participating in the study would greatly benefit the client's financial situation
Answer: A, C
Explanation: A) Giving false information would violate the client's right to full disclosure.
B) Telling a mutual friend about the client's involvement would violate the client's right to confidentiality.
C) Withholding information would violate the client's right to full disclosure.
D) Providing the client's name as a study participant would violate the client's right to confidentiality; however, this would not affect the client's right to full disclosure.
E) Suggesting that study participation would benefit the client financially could be viewed as a form of coercion or undue influence and thus be considered unethical, but it would not affect the client's right to full disclosure.
Page Ref: 2763
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Defining what is evidence-based practice. | Nursing Process: Assessment
Learning Outcome: 45.3. Summarize the fundamentals of research methodology.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

11) A nurse working in a home health agency is asked to participate on a committee that is looking to incorporate evidence-based nursing care. Which step should the committee complete first when implementing evidence-based practice (EBP)?
A) Compile a list of questions.
B) Research evidence-based practices that can be implemented.
C) Evaluate the results of different research projects.
D) Suggest that individual staff members try new means of delivering care.
Answer: A
Explanation: A) Following committee formation, the next step in the EBP implementation process would be to compile a list of clinical questions that are relevant to nursing practice within the agency.
B) It is not appropriate to research specific nursing practices until pertinent clinical questions have been asked.
C) Results cannot be evaluated until research has been reviewed and practice has been changed.
D) Suggesting that staff nurses try new methods of care may violate the agency's policies; also, new care methods should be tried and evaluated in an orderly fashion.
Page Ref: 2763
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Defining what is evidence-based practice. | Nursing Process: Planning
Learning Outcome: 45.4. Analyze the four steps of developing evidence-based practice.

MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

12) The nurse is planning a research project comparing the use of fingerstick blood glucose testing with the use of alternative sites for adult male clients. Which elements of the PICOT formulation of the clinical question still need to be defined? **Select all that apply.**
A) People
B) Issue
C) Comparison
D) Outcome
E) Time
Answer: D, E
Explanation: A) The people in this study are adult men with diabetes.
B) The issue is effective testing for blood glucose levels.
C) The comparison is between adult men using different testing sites.
D) According to the PICOT formulation, the clinical question still needs to specify an outcome.
E) According to the PICOT formulation, the clinical question still needs to specify a time frame for the study.
Page Ref: 2764
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.B.1. Participate effectively in appropriate data collection and other research activities. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Knowledge and Science: Translate research into practice in order to promote quality and improve practices. | Nursing Process: Planning
Learning Outcome: 45.4. Analyze the four steps of developing evidence-based practice.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

13) A nurse is preparing to conduct a research study and wants to do a literature search for relevant articles. Which sections should the nurse expect to find in each search result? **Select all that apply.**

A) Abstract
B) Methods
C) Funding
D) Results
E) References

Answer: A, B, D, E

Explanation: A) The abstract provides a summary of the entire content of the journal article.
B) The methods section describes in detail all aspects and methods of the study.
C) Funding information is not a necessary element of a research article.
D) The results section reports statistical data.
E) The references section lists source materials and other resources for additional information.

Page Ref: 2766
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.B.4. Read original research and evidence reports related to area of practice. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Electronic databases; literature retrieval; evaluating data for validity and reliability; evidence and best practices for nursing. | Nursing Process: Implementation
Learning Outcome: 45.4. Analyze the four steps of developing evidence-based practice.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

14) A nursing student who is providing care for an assigned client knows that the information documented in the client's nursing care plan could potentially be used in research to optimize client care. Which type of research is used to convert research knowledge into healthcare applications for improved outcomes?
A) Translational research
B) Transformational research
C) Quantitative research
D) Qualitative research
Answer: A
Explanation: A) Translational research is a systematic approach of converting research knowledge into applications of healthcare for improved client outcomes. When scientific evidence is translated into practical applications, human health can be improved. Information can flow back and forth between researchers and clinicians to further investigate diseases and human response to them.
B) Transformation is not a type of research.
C) Quantitative research uses precise measurement to collect data and analyze it statistically for a summary and a description of the resulting findings or to test relationships among variables.
D) Qualitative research investigates a question through narrative data that explores the subjective experiences of human beings and can provide nursing with a better understanding of the client's perspective.
Page Ref: 2760
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.C.3. Value the concept of EBP as integral to determining best clinical practice. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 45.1. Summarize the evolution of evidence-based practice.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

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15) A nurse manager is encouraging staff on the unit to go back to school and "become professionals, not just workers" by "increasing" their knowledge through education and networking. Which criteria for nursing to be recognized as a profession is the nurse manager highlighting? **Select all that apply.**
A) Joining professional organizations
B) Following a code of ethics
C) Having specialized education requirements
D) Conducting ongoing research
E) Having autonomy
Answer: A, C, E
Explanation: A) Although all of the answer choices are criteria for nursing to be recognized as a profession, in this situation, the nurse manager is highlighting the importance of joining professional organizations through networking.
B) The nurse manager is not focusing on the code of ethics.
C) Although all of the answer choices are criteria for nursing to be recognized as a profession, in this situation, the nurse manager is highlighting the importance of specialized education.
D) The nurse manager is not focusing on conducting research.
E) Having autonomy is implied because more education leads to more autonomy.
Page Ref: 2763
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.B.6. Participate in structuring the work environment to facilitate integration of new evidence into standards of practice. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Retrieve research findings and other sources of information; critique research to judge its value and usefulness; evaluate the strength of evidence for application of research findings to clinical practice. | Nursing Process: Implementation
Learning Outcome: 45.2. Outline the relationship between evidence-based practice and other concepts.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

16) A home health nurse who is visiting a client to complete a wound dressing notes that the client has a flat affect and is not as responsive as during previous visits. The nurse calls the client's primary healthcare provider for a psychiatric referral. By recognizing the signs and symptoms of possible depression, the nurse is exhibiting which concept associated with evidence-based practice?
A) Clinical decision making
B) Advocacy
C) Professional behavior
D) Accountability
Answer: A
Explanation: A) The nurse is engaging in clinical decision making informed by evidence from the research. The nurse's decision to seek a psychiatric referral reflects familiarity with the signs and symptoms of depression, as widely documented in the literature. It also reflects an understanding that psychiatric care may be necessary to achieve the best possible outcome for this client.
B) The nurse is not demonstrating advocacy in this situation.
C) The nurse is not demonstrating professional behavior in this situation.
D) The nurse is not demonstrating accountability in this situation.
Page Ref: 2761
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.C.3. Value the concept of EBP as integral to determining best clinical practice. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Assessment
Learning Outcome: 45.1. Summarize the evolution of evidence-based practice.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

17) Which type of research investigates a question through narrative data that explores the subjective experiences of human beings and can provide nursing with a better understanding of clients' perspectives?
A) Quantitative research
B) Thematic research
C) Qualitative research
D) Clinical research
Answer: C
Explanation: A) Quantitative research uses precise measurement to collect data and analyze the data statistically for a summary and a description of the resulting findings or to test relationships among variables.
B) Goals of thematic research include the identification of patterns and themes.
C) Qualitative research investigates a question through narrative data that explores the subjective experiences of human beings and can provide nursing with a better understanding of the subjects' perspective.
D) Clinical research refers to any type of research (qualitative or quantitative) that seeks answers to questions that will ultimately improve patient care.
Page Ref: 2762
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Defining what is evidence-based practice. | Nursing Process: Assessment
Learning Outcome: 45.3. Summarize the fundamentals of research methodology.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

18) Prior to conducting research, nurse researchers must have their research protocols approved by which body?

A) The American Nurses Association
B) The U.S. Department of Health and Human Services
C) The journal in which the researchers plan to publish their results
D) An institutional review board

Answer: D

Explanation: A) The American Nurses Association is not required to review research protocols.
B) The US Department of Health and Human Services is not required to review research protocols.
C) Journals are interested in research after it has been conducted, not before.
D) Prior to undertaking research, nurse researchers must have their protocols reviewed and approved by an institutional review board (IRB). The IRB is responsible for ensuring that the research protocols adhere to ethical standards.

Page Ref: 2762
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Defining what is evidence-based practice. | Nursing Process: Implementation
Learning Outcome: 45.3. Summarize the fundamentals of research methodology.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

19) Which measure would be most directly aimed at upholding the principle of respect for persons?
A) A policy requiring that any research involving pediatric subjects undergo an extra level of ethical scrutiny prior to approval
B) A policy stating that all data gathered during research must be stripped of information that links it to individual research subjects
C) A policy stating that a research project must be immediately suspended should any of the participants experience an unexpected adverse event
D) A policy requiring that all participants in a research effort receive financial compensation
Answer: A
Explanation: A) The principle of respect for persons involves acknowledging and protecting the autonomy of all individuals, including individuals whose capacity to exercise autonomy is diminished because of disability, illness, circumstances that restrict liberty, or immaturity. Thus, this principle would underlie a policy providing extra protection for pediatric research subjects.
B) A policy requiring the removal of personally identifying information would be more closely linked to the concept of justice.
C) A policy requiring the suspension of a research project following unforeseen adverse effects would be more closely linked to the principle of beneficence.
D) It is unlikely that an organization would have a policy requiring financial compensation for all research subjects, as this might be considered a form of undue influence.
Page Ref: 2763
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Defining what is evidence-based practice. | Nursing Process: Assessment
Learning Outcome: 45.3. Summarize the fundamentals of research methodology.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

20) Which question would be considered a foreground question when included in a nursing research project?
A) "Who is at greatest risk for the development of gestational diabetes?"
B) "What are the side effects of this class of antipsychotic medications?"
C) "How does use of behavioral interventions compare to use of pharmacological therapies in treating hypertension?"
D) "What organisms most commonly cause bacterial pneumonia?"
Answer: C
Explanation: A) The question about gestational diabetes is a background question because it is a general question that seeks more information about a topic, such as diseases or medications.
B) The question about side effects of medications is a background questions because it is a general question that seeks more information about a topic, such as diseases or medications.
C) Foreground questions are somewhat narrow in focus and are about specific clinical issues. They are useful for finding nursing interventions that improve patient outcomes; in other words, they identify useful information about direct patient care. The question that compares behavioral and pharmacological interventions for hypertension would be considered a foreground question.
D) The question about organisms that cause bacterial pneumonia is a background questions because it is a general question that seeks more information about a topic, such as diseases or medications.
Page Ref: 2764
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.A.2. Describe EBP to include the components of research evidence, clinical expertise and patient/family values. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Knowledge and Science: Defining what is evidence-based practice. | Nursing Process: Assessment

Learning Outcome: 45.3. Summarize the fundamentals of research methodology.
MNL LO: Analyze the concept of evidence-based practice and its application to nursing care.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 46 Healthcare Systems

The Concept of Healthcare Systems

1) The nurse is caring for a client who sustained multiple injuries in an automobile accident. As a part of secondary prevention for this client, which intervention does the nurse include in the plan of care?
A) Promote wellness.
B) Screen for early disease.
C) Restore the client to previous functioning.
D) Prevent the progression of more symptoms.
Answer: D
Explanation: A) Promoting wellness is considered primary prevention.
B) Screening for early disease is primary prevention.
C) Rehabilitation is tertiary prevention and is aimed at restoring the client to the previous level of functioning.
D) Prevention of the progression of symptoms is secondary prevention.
Page Ref: 2774
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.B.10. Engage patients or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles). | Nursing Process: Planning
Learning Outcome: 46.1. Differentiate the three levels of preventive healthcare systems.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

2) A nurse educator is teaching a group of students about managed care. The educator knows that the students have understood the concept when they state that managed care has which emphasis? **Select all that apply.**

A) Bringing services of multiple providers to the client
B) Organizing healthcare services around the stated needs of the client
C) Providing cost-effective care
D) Ensuring high-quality care
E) Using a health maintenance organization model

Answer: C, D, E

Explanation: A) Case management describes a range of models for integrating and delivering healthcare services from multiple providers to the client.
B) Client-focused care is a delivery model that organizes healthcare services around the stated needs of the client.
C) Managed care describes a healthcare system that emphasizes cost-effective care.
D) Managed care describes a healthcare system that emphasizes quality care.
E) The primary managed care models are health maintenance organizations and preferred provider organizations.

Page Ref: 2777
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV.A.1. Describe strategies for learning about the outcomes of care in the setting in which one is engaged in clinical practice. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Context and Environment: Healthcare systems. | Nursing Process: Evaluation

Learning Outcome: 46.3. Differentiate the three common models of healthcare.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

3) The manager of a small clinic has cross-trained the nurses to perform electrocardiogram (ECG) testing, phlebotomy, and some respiratory therapy interventions. This clinic is providing client-focused care. Which action demonstrates this delivery model in action?
A) Many disciplines collaborate to provide client care.
B) Client care is carefully managed to control costs.
C) If a client complains of breathing difficulty, nurses concentrate on respiratory therapy for that client.
D) Client progress is efficiently tracked.
Answer: C
Explanation: A) Collaboration is not a distinguishing feature of this model.
B) Careful cost management is not a distinguishing feature of this model.
C) In client-focused care, the needs of the client, physical or emotional, as expressed by the client drive care decisions are demonstrated.
D) Efficient tracking of client progress is not a distinguishing feature of this model.
Page Ref: 2777
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.4. Examine how the safety, quality and cost effectiveness of healthcare can be improved through the active involvement of patients and families. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Healthcare systems. | Nursing Process: Implementation
Learning Outcome: 46.1. Differentiate the three levels of preventive healthcare systems.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

4) The nurse is planning a community health fair at a local community center. Which goals regarding health promotion does the nurse plan to highlight at the event? **Select all that apply.**
A) Change and modify goals as health needs change
B) Clients to be able to assess and evaluate their health needs
C) Clients to promote health in other individuals
D) Promote cost-saving techniques to healthcare providers
E) Prevent disease by imitating nursing techniques
Answer: A, B
Explanation: A) The nurse has an integral role in health promotion. The nurse's aim should be to teach clients how to remain healthy, thus preserving wellness. The overarching goal is for clients to be able to assess, implement, evaluate and, as their health needs change, modify them.
B) The nurse has an integral role in health promotion. The nurse's aim should be to teach clients how to remain healthy, thus preserving wellness. The overarching goal is to ensure that clients understand the importance of setting health goals for themselves and their children.
C) Teaching clients to promote health in others is not a goal for health promotion.
D) Saving costs to healthcare providers is not a goal for health promotion.
E) Preventing disease by imitating nursing techniques is not a goal for health promotion.
Page Ref: 2774
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.B.10. Engage patients or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles). | Nursing Process: Planning
Learning Outcome: 46.1. Differentiate the three levels of preventive healthcare systems.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

5) For which reason should job seekers in the healthcare sector pay attention to advances in healthcare technology?
A) Advances in technology require specialized personnel.
B) Advances in technology involve policies and strategies at the organizational level.
C) Changing demographics increase the need for new jobs.
D) Technology plays a role in health literacy.
Answer: A
Explanation: A) Many advances in technology require specialized personnel, creating new opportunities for individuals seeking employment in the healthcare sector.
B) Advances in technology may involve policies and strategies at the organizational level, but that is not of primary interest to job seekers.
C) Changing demographics do not necessarily involve technology.
D) Technology does play a role in health literacy, but this is not of primary interest to job seekers.
Page Ref: 2776
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.10. Engage patients or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Impact of continual knowledge explosion and constant evolution of technology. | Nursing Process: Planning
Learning Outcome: 46.2. Outline the factors affecting delivery of healthcare.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

6) The nurse is taking care of a client who is being discharged but will need home nursing care, physical therapy, and speech therapy. Which framework helps the client who has multiple care needs?
A) Case management
B) Client-focused care
C) Managed care
D) A health maintenance organization
Answer: A
Explanation: A) Interprofessional teams led by a case manager are at the heart of successful case management. Case management is essential when a client has multiple care needs and requires the services of multiple providers. The goal of case management is to reach and then maintain the individual's optimum level of health, quality of life, and activities of daily living by ensuring that the individual's healthcare needs are met.
B) Client-focused care is focused on the client's expressed needs but not specifically on providing the services of multiple providers.
C) Managed care provides high-quality care at a lower cost but is not specifically focused on providing the services of multiple providers.
D) HMOs are a kind of managed care.
Page Ref: 2777
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.4. Examine how the safety, quality and cost effectiveness of healthcare can be improved through the active involvement of patients and families. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Healthcare systems. | Nursing Process: Planning
Learning Outcome: 46.3. Differentiate the three common models of healthcare.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

7) If more older adults live in Mississippi than elsewhere in the United States and clients in Massachusetts have much greater access to health services than clients elsewhere in the United States, then what does this imply about access of older adults to healthcare in Mississippi?
A) The likelihood is that more specialists serving older populations will work in Mississippi than in Massachusetts.
B) Their access to healthcare should be roughly equal to that of older adults living in Massachusetts but with a different mix of providers.
C) The need for services will be much greater for older adults in Mississippi than in Massachusetts due to a decreasing number of healthcare providers.
D) There will be much more robust rural services for older adults in Mississippi than in Massachusetts.
Answer: C
Explanation: A) Nothing here implies that there will be fewer specialists working in Massachusetts.
B) Nothing here indicates anything about the mix of providers in either state and rural services tend to be lacking.
C) If Massachusetts is a state with a much greater than average access for clients to health services, it is likely that states such as Mississippi offer less access to these services and fewer primary care physicians, and Mississippi's greater population of older adults will lack access to the care they need.
D) No states have enough primary care providers to meet their needs. Aggravating this problem is the growing number of healthcare providers who specialize.
Page Ref: 2779
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.5. Examine common barriers to active involvement of patients in their own healthcare processes. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Read and interpret data. | Nursing Process: Assessment
Learning Outcome: 46.4. Outline the factors that limit access to healthcare.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

8) The nurse educator is presenting information to a group of nursing students regarding uninsured and underinsured clients. Which example of this problem should the educator share with the students?
A) "Delays of diagnoses lead to higher mortality and morbidity rates."
B) "Delays in health coverage for children put the health provider at risk for litigation."
C) "Immunizations are free for children at public health clinics."
D) "Older adults are less likely to be treated for falls."
Answer: A
Explanation: A) Those who are not insured, or are underinsured, often do not seek treatment in a timely manner due to finances. As a result, diagnosis is made in the later stages of the disease, resulting in a decreased chance of survival and an increased cost of treatment. The exposure of healthcare providers to litigation is not an aspect of this issue.
B) The exposure of healthcare providers to litigation is not an aspect of this issue. Children who do not have insurance have been denied health coverage in the past, but this is no longer the case.
C) Immunizations are free for children at public health clinics, so this is not an example of the problem.
D) Adults aged 65 and older are eligible for Medicare and have access to healthcare for falls and other medical problems.
Page Ref: 2777
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.4. Examine how the safety, quality and cost effectiveness of healthcare can be improved through the active involvement of patients and families. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles). | Nursing Process: Planning
Learning Outcome: 46.7. Explain the issues with allocation of resources and the nurse's role in decision making.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

9) The nurse in an urgent care center is assessing an adult client who is diagnosed with the flu. The nurse discusses the need for flu shots with the client, who states, "I cannot afford the shots. I do not have health insurance." Which suggestion by the nurse is most appropriate?
A) Seek preventive care at the local health department.
B) Find a primary care physician who will give free care.
C) Obtain the flu shot at a local pharmacy.
D) Get the shot every year in the emergency department.
Answer: A
Explanation: A) Public health organizations, such as local health departments, are available for those who are uninsured or underinsured. This provides the client with health promotion and preventive measures as well as treatment when the client is ill.
B) The nurse should not give the client a vague message that they need to find a care provider who gives free care. Rather, the nurse would refer the client to a specific place that can meet the client's needs.
C) Flu shots at pharmacies require payment by the client and are not the solution for those with a low income and no insurance.
D) Using the emergency department for preventive care is part of the increased cost of healthcare.
Page Ref: 2780
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.4. Examine how the safety, quality and cost effectiveness of healthcare can be improved through the active involvement of patients and families. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Apply evidence to support decision making in situations characterized by ambiguity and uncertainty. | Nursing Process: Implementation
Learning Outcome: 46.7. Explain the issues with allocation of resources and the nurse's role in decision making.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

10) A client asks the nurse, "How am I going to pay for a surgery? I'm broke, but I've been so sick." Which statement regarding the Affordable Care Act (ACA) may be applicable to this client's situation?
A) "The ACA extends coverage to people who do not qualify for public assistance and whose employers do not offer health insurance."
B) "Unfortunately, you will probably be denied coverage because of your existing condition."
C) "Most insurance premiums will be more and some less; you will have to shop around."
D) "Because the rate of inflation is slowing, the ACA will also help curb medical costs."
Answer: A
Explanation: A) The ACA was created to ensure that all U.S. citizens have access to affordable, quality care and to curb the growth of healthcare costs. Under the ACA, a client cannot be denied coverage because of an existing condition.
B) Under the ACA, a client cannot be denied coverage because of an existing condition.
C) Insurance premiums should remain the same.
D) The ability of the ACA to curb medical costs is irrelevant to this client's needs.
Page Ref: 2777-2778
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.5. Examine common barriers to active involvement of patients in their own healthcare processes. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Apply evidence to support decision making in situations characterized by ambiguity and uncertainty. | Nursing Process: Implementation
Learning Outcome: 46.7. Explain the issues with allocation of resources and the nurse's role in decision making.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

11) The nurse on the pediatric unit contemplates the changes in healthcare insurance when speaking with other colleagues. Which aspects of the Affordable Care Act (ACA) affect children favorably? **Select all that apply.**
A) Insurance companies cannot deny coverage based on preexisting conditions.
B) Insurance companies cannot drop children who have serious illnesses.
C) Benefits are paid through private benefactors.
D) All children are covered regardless of whether the parents are covered.
E) The government must make appropriate arrangements for children based on need.
Answer: A, B
Explanation: A) Children with healthcare coverage receive preventive care and are more likely to attend school regularly and have better focus. The ACA will affect children favorably because insurance companies will no longer be able to deny coverage to children based on preexisting conditions.
B) The ACA will affect children favorably because insurance companies will no longer be able to drop insured individuals and/or their dependents who experience serious illness.
C) Under the ACA, benefits are not paid through private benefactors.
D) Coverage is intended for all U.S. citizens, not just children.
E) Coverage is intended for all U.S. citizens, not only based on an assessment of need.
Page Ref: 2778
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.5. Examine common barriers to active involvement of patients in their own healthcare processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Apply evidence to support decision making in situations characterized by ambiguity and uncertainty. | Nursing Process: Planning
Learning Outcome: 46.7. Explain the issues with allocation of resources and the nurse's role in decision making.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

12) The nurse knows that Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) of 1986 to prevent which action by emergency services?

A) Refusing to treat uninsured clients
B) Servicing suburban clients only
C) Stopping the poor from using emergency services as primary care
D) Providing free examinations to the poor

Answer: A

Explanation: A) In 1986, Congress enacted the Emergency Medical Treatment and Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Prior to the enactment of this law, providers of emergency services often refused to treat clients who were uninsured and who could not afford to pay for services.

B) EMTALA does not have to do with provisions for nonsuburban clients.

C) EMTALA does not have to do with ensuring the poor do not use emergency services as primary care.

D) EMTALA does not have to do with preventing free examinations to the poor.

Page Ref: 2778

Cognitive Level: Remembering

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: I.A.4. Examine how the safety, quality and cost effectiveness of healthcare can be improved through the active involvement of patients and families. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Apply evidence to support decision making in situations characterized by ambiguity and uncertainty. | Nursing Process: Implementation

Learning Outcome: 46.4. Outline the factors that limit access to healthcare.

MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

13) The nurse taking care of a client in the clinic notes that the client comes in twice per week, but never seems to have anything majorly wrong. For which reason should the client receive education about self-care?
A) The client's perception of need will change, promoting appropriate and timely healthcare.
B) The client will continue to come to the clinic seeking help until someone helps the client.
C) The client will seek affordable insurance by which to gain appropriate healthcare.
D) The client will learn to seek healthcare services from legitimate sources.
Answer: A
Explanation: A) A client's perceived need for healthcare services can be a barrier to access. It may cause clients to seek care that is unnecessary or care that is necessary but provided at an inappropriate and often more expensive place of service than needed. The nurse can change the clients' perception of need (thereby promoting appropriate and timely healthcare) by managing client care, teaching adults about self-care and the care of their children, and teaching clients when and how to access appropriate care.
B) An educated client will not continue to come to the clinic when there is no need.
C) The issue here is not the need for affordable insurance.
D) The issue here is not the inability to recognize legitimate sources of care.
Page Ref: 2780
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.A.5. Examine common barriers to active involvement of patients in their own healthcare processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Apply evidence to support decision making in situations characterized by ambiguity and uncertainty. | Nursing Process: Planning
Learning Outcome: 46.2. Outline the factors affecting delivery of healthcare.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

14) At a local seminar discussing healthcare resources, the nurse discusses the phenomenon that healthcare resources are declining while costs for healthcare are increasing. An older adult in attendance asks the speaker why it has become so difficult to obtain needed care and services. Which response should the nurse make?
A) "There is increased cost due to the increased incidence of malpractice lawsuits."
B) "There is a decrease in the number of adults needing care."
C) "There are not enough medications produced for those who need them."
D) "There are plenty of nurses but not enough doctors."
Answer: A
Explanation: A) Services are reduced because of increasing costs and needs. One reason for increased costs is the practice of defensive medicine because of the risks of malpractice litigation.
B) Over the next decade, there will be an increasing number of older adults needing medical care.
C) The cost of supplies and medication, not the amount available, is the reason for decreased services.
D) There is an increasing shortage of nurses and physicians.
Page Ref: 2781
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.9. Assess level of patient's decisional conflict and provide access to resources. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Act in accordance with policies and procedures that guide economic behavior in the practice environment. | Nursing Process: Implementation

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Learning Outcome: 46.4. Outline the factors that limit access to healthcare.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

15) The nurse is assessing an older adult client in the free clinic. The nurse notes that the client's cholesterol level is higher than the target and has increased since the client's last visit. The nurse assesses the client for possible causes for this increase. After determining that the client has not changed dietary and exercise habits, which conclusion by the nurse is the most appropriate?
A) The client has increased egg consumption.
B) The client may not be taking medications as prescribed.
C) The client needs more aerobic activity.
D) The client may be experiencing high triglyceride levels.
Answer: B
Explanation: A) The client has not changed dietary habits.
B) Rationing is a method used by individuals, insurance companies, and the government to prevent increases in the cost of healthcare or to reduce the cost of healthcare. Individuals ration when they decide to provide self-care for an illness or injury rather than seeking care from a healthcare provider. In the case of this client, rationing of prescribed medications is likely the issue because dietary and exercise habits have not changed.
C) The client has not changed exercise habits.
D) Concluding that the client may be experiencing high triglyceride levels does not identify a reason for the increased cholesterol level.
Page Ref: 2783
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: I.B.9. Assess level of patient's decisional conflict and provide access to resources. | AACN Domains and Competencies: VII.10. Collaborate with others to develop an intervention plan that takes into account determinants of health, available resources, and the range of activities that contribute to health and prevention of illness, injury, disability. and premature death. | NLN Competencies: Context and Environment: Act in accordance with policies and procedures that guide economic behavior in the practice environment. | Nursing Process: Evaluation
Learning Outcome: 46.7. Explain the issues with allocation of resources and the nurse's role in decision making.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

16) A young mother brings her children to the health department for routine immunizations. The mother is crying because she lost her job and fears that her asthmatic daughter may be denied appropriate healthcare because she is unable to pay for it. The nurse realizes that many clients are experiencing these fears. Which action by the nurse would have the greatest impact for all clients who experience this fear?
A) Reminding the client that everything will be fine
B) Becoming involved in the American Nurses Association (ANA)
C) Moving to an area that needs healthcare workers
D) Giving the client medications and supplies from the clinic at no charge
Answer: B
Explanation: A) Telling a worried parent that everything will be fine is giving the client potentially false hope.
B) Because nurses are in a position to be closely associated with the needs of clients, nurses need to be involved in professional organizations that participate in educating legislators at the local and national levels. An example of such an organization is the American Nurses Association (ANA).
C) For nurses to move to areas needing healthcare workers would not help with the rising cost of healthcare.
D) Giving clients supplies and medications from the clinic increases costs and will not help solve the overall problem with healthcare today.
Page Ref: 2784
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: I.B.9. Assess level of patient's decisional conflict and provide access to resources. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Act in accordance with policies and procedures that guide economic behavior in the practice environment. | Nursing Process: Implementation

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Learning Outcome: 46.7. Explain the issues with allocation of resources and the nurse's role in decision making.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

17) A client in the clinic asks the nurse about a medication seen on television. When the nurse suggests a generic, cheaper version of the medication, the client is resistant to this recommendation. Of which type of situation is this an example?
A) Healthcare treatment choices that drive up costs
B) Factually misleading advertisements by pharmaceutical manufacturers
C) Client-focused care
D) The need for stricter Food and Drug Administration (FDA) safeguards for consumers
Answer: A
Explanation: A) Inappropriate healthcare treatment choices by consumers have also contributed to increases in healthcare costs. Mass advertising by pharmaceutical manufacturers and specialty treatment centers directed at consumers have contributed to these inappropriate treatment choices.
B) This is not an example of advertisements being factually misleading.
C) A client being guided in healthcare decisions by an advertisement is not an example of client-focused care.
D) This is not an example of an argument for stricter FDA safeguards.
Page Ref: 2781
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.9. Assess level of patient's decisional conflict and provide access to resources. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Act in accordance with policies and procedures that guide economic behavior in the practice environment. | Nursing Process: Assessment

Learning Outcome: 46.7. Explain the issues with allocation of resources and the nurse's role in decision making.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

18) The nurse educator is teaching a group of nursing students about the methods that are used by insurance companies to ration healthcare resources. Which method does the educator include in the teaching session regarding this topic?
A) Denying coverage for services not supported by research
B) Covering clients for preexisting conditions only
C) Providing health savings accounts for covered individuals
D) Covering organ donations
Answer: A
Explanation: A) Rationing is one means of allocating healthcare resources. Rationing is a method used by individuals, insurance companies, and the government to prevent increases in the cost of healthcare or to reduce the cost of healthcare. Methods used by insurance companies to ration healthcare resources include denial of coverage for services (e.g., services deemed to be experimental or those that are not supported by scientific evidence that proves their efficacy).
B) Covering clients for preexisting conditions only is not a method of rationing used by insurance companies.
C) Providing health savings accounts is not a method of rationing used by insurance companies.
D) Organ donation coverage is not a method of rationing used by insurance companies.
Page Ref: 2783
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.9. Assess level of patient's decisional conflict and provide access to resources. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Act in accordance with policies and procedures that guide economic behavior in the practice environment. | Nursing Process: Implementation

Learning Outcome: 46.7. Explain the issues with allocation of resources and the nurse's role in decision making.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

19) As a working professional concerned with proper resource allocation, the nurse knows that one reason to join the American Nurses Association (ANA) is for which opportunity?
A) Participate in national discussions about resources
B) Draw attention to the nurse's credentials
C) Determine how to fight for resources locally
D) Advocate for resources through different business sources
Answer: A
Explanation: A) Nurses must be aware of, and participate in, discussions that affect the allocation of healthcare resources in the workplace, in their communities, and at the federal level. Nurses are uniquely placed to advocate on behalf of clients when allocation of resources is being considered in their communities. They may advocate by talking with local legislators, writing to politicians, and engaging in discussions in their neighborhoods and social groups. As working professionals, nurses have the opportunity to participate in national discussions about resources through a number of professional organizations, such as the American Nurses Association.
B) ANA membership as regards resource allocation is not a means of building the nurse's credentials.
C) ANA membership as regards resource allocation is not a means of fighting for local resources.
D) ANA membership as regards resource allocation is not a means of enlisting business sources in the provision of resources.
Page Ref: 2784
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.9. Assess level of patient's decisional conflict and provide access to resources. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Act in accordance with policies and procedures that guide economic behavior in the practice environment. | Nursing Process: Implementation
Learning Outcome: 46.7. Explain the issues with allocation of resources and the nurse's role in decision making.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

Exemplar 46.A Emergency Preparedness

1) The nurse is participating on a local council as an advisor regarding community needs during an emergency. Which recommendation regarding community needs during an emergency that the nurse might include when advising the council would be involved in the emergency response phase?
A) A coordinated emergency preparedness plan
B) Assembling disaster kits
C) Programs to restore the community
D) The identification of potential hazards to the community
Answer: A
Explanation: A) A coordinated response to emergencies occurs during the emergency response phase. Although a comprehensive disaster plan is developed in the preparedness phase, it is enacted in the emergency response phase.
B) Assembling disaster kits is part of the preparedness phase.
C) Programs to restore the community are part of the recovery phase.
D) During the mitigation phase of the emergency response, the community identifies the potential hazards and takes measures to prevent or minimize the emergency.
Page Ref: 2785
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: V.C.1. Value the contributions of standardization/reliability to safety. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles). | Nursing Process: Planning
Learning Outcome: 46.A. Analyze emergency preparedness as it relates to healthcare systems. Describe the four phases of emergency management.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

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2) A hospital in the community has been notified of a multi-car crash on the interstate that will result in the transfer of many injured clients to the hospital. As part of the emergency response, the charge nurses in the emergency department (ED) and intensive care unit (ICU) are responsible for which tasks? **Select all that apply.**

A) Assigning care for the clients as they are admitted to the unit
B) Exceeding their scope of practice when and if required
C) Assessing the priority of the current clients for the ED or ICU
D) Delegating staff nurses to gather needed supplies for the arriving clients
E) Providing any care that any patient needs

Answer: A, C, D

Explanation: A) The charge nurse would assign care for the clients who are admitted to the unit.

B) During the crisis, nurses should be constantly aware of their defined scope of practice and must not exceed it even when circumstances would seem to dictate otherwise.

C) The charge nurses in each unit are responsible for assessing the current clients and recommending to the physicians those clients who can be moved to make room for clients needing more immediate care.

D) The charge nurse would delegate the gathering of supplies to the staff nurses.

E) They should not use their time to provide care that will be of minimal or questionable benefit.

Page Ref: 2786, 2792

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Scope of practice, roles, and responsibilities of healthcare team members, including overlaps. | Nursing Process: Implementation

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Learning Outcome: 46.A. Analyze emergency preparedness as it relates to healthcare systems. Explain the role of nurses in emergency management and response.

MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

3) The charge nurse assesses clients during a mass casualty incident (MCI) and transfers some to other units but discharges others to home. In planning for the admission of critically ill clients from the emergency department, to which nurses will the charge nurse assign the new clients when admitted to the unit?

A) Nurses with risk-reduction knowledge
B) Nurses with advanced assessment skills
C) Nurses with impeccable ethics
D) Nurses with exceptional self-care methods

Answer: B

Explanation: A) Nurses do need to have sufficient risk-reduction knowledge, however, during the admission of victims, the charge nurse would want the highly competent nurses caring for the new clients.

B) During the admission of injured clients, the charge nurse would assign the new clients to those nurses with advanced assessment, technical, and communication skills. Advanced practice nurses who have received training in emergency and trauma care will have significantly greater responsibilities than nurses with less training.

C) Nurses do need to have good ethics, however, during the admission of victims, the charge nurse would want the highly competent nurses caring for the new clients.

D) Nurses do need to have appropriate self-care knowledge during emergency responses, however, during the admission of victims, the charge nurse would want the highly competent nurses caring for the new clients.

Page Ref: 2787
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care

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Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Scope of practice, roles, and responsibilities of healthcare team members, including overlaps. | Nursing Process: Implementation

Learning Outcome: 46.A. Analyze emergency preparedness as it relates to healthcare systems. Explain the role of nurses in emergency management and response.

MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

4) A group of nurses attend an in-service regarding emergency preparedness for the hospital. One of the nurses has three small children and lives in a two-story house in the suburbs. After the class, the nurse plans to initiate which action to enhance family safety?
A) Training her family in performing nursing interventions to take part in an emergency response
B) Obtaining a fire escape ladder for the second floor of the home
C) Developing a plan for her family to join her in the event of an emergency
D) Ensuring she and her family move to a safe area unlikely to be involved in a disaster
Answer: B
Explanation: A) The nurse's family is not qualified to perform nursing interventions.
B) During the preparedness phase, nurses must also develop an emergency plan for themselves and their immediate families. When this plan is complete, nurses can be confident that their families are prepared to weather an emergency in relative safety. With this assurance, nurses who choose to assist in a disaster or who are required to remain at the hospital during a disaster will be able to leave their families without delay and remain available until no longer needed. Part of this plan should include a means of escape such as a fire escape ladder.
C) The nurse's family should go to a safe place in an emergency, not join the nurse where she is.
D) No place is completely safe from all potential disasters.
Page Ref: 2786
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Apply evidence to support decision making in situations characterized by ambiguity and uncertainty. | Nursing Process: Implementation
Learning Outcome: 46.A. Analyze emergency preparedness as it relates to healthcare systems. Explain the role of nurses in emergency management and response.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

5) A nurse recently attended a seminar that discussed the many threats to homeland security. As nurse manager of the emergency department, the nurse is responsible for planning for emergencies from bioterrorism. Which agents does the nurse include when planning for bioterrorism? **Select all that apply.**
A) Anthrax
B) Tuberculosis
C) Cancer
D) Flu
E) Smallpox
Answer: A, E
Explanation: A) Anthrax is an agent of highest concern in regard to bioterrorism.
B) Tuberculosis has not been developed into a biological threat and would not kill the number of people that smallpox would.
C) Cancer has not been developed into a biological threat and would not kill the number of people that smallpox would.
D) Flu has not been developed into a biological threat and would not kill the number of people that smallpox would.
E) Smallpox is an agent of highest concern in regard to bioterrorism.
Page Ref: 2791
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: III.A.1. Demonstrate knowledge of basic scientific methods and processes. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Apply evidence to support decision making in situations characterized by ambiguity and uncertainty. | Nursing Process: Planning
Learning Outcome: 46.A. Analyze emergency preparedness as it relates to healthcare systems. Summarize the methods used for handling bioterrorism disasters.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

6) The nurse is performing START triage for clients injured in a terrorist attack. Which client would the nurse classify as expectant?
A) Client is breathing but has an absent radial pulse.
B) Client has a respiratory rate below 30.
C) Client is apneic after positioning of an airway.
D) Client is breathing adequately with a radial pulse but does not obey commands.
Answer: C
Explanation: A) A client who is breathing with an absent radial pulse requires immediate intervention.
B) A client with a respiratory rate below 30 requires immediate intervention.
C) A client who is apneic after the positioning of an airway would be tagged as black, expectant, meaning the client is not expected to survive.
D) A client who is breathing adequately with a radial pulse but unable to obey commands requires immediate intervention.
Page Ref: 2788
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.4 Diagnose actual or potential health problems and needs. | NLN Competencies: Context and Environment: Apply evidence to support decision making in situations characterized by ambiguity and uncertainty. | Nursing Process: Diagnosis
Learning Outcome: 46.A. Analyze emergency preparedness as it relates to healthcare systems. Explain the role of nurses in emergency management and response.

MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

7) The nurse is working with an emergency response team following massive flooding caused by a hurricane. Which activity will the nurse perform when working with the Clinical Outreach Communication Activity (COCA) team?
A) Have two-way communication with the Centers for Disease Control and Prevention (CDC) concerning infection risks.
B) Facilitate communication between doctors in the field during a disaster and their healthcare team.
C) Provide resources to the community during times of disaster.
D) Provide expert advice to other nurses during natural disasters.
Answer: A
Explanation: A) The CDC manages the COCA to ensure that clinicians have up-to-date information. The COCA is designed to provide two-way communication between clinicians and the CDC about emerging health threats such as pandemics, natural disasters, and terrorism. The COCA keeps a list of emergency preparedness and training resources offered by federal agencies and COCA partners.
B) COCA does not enable communication between doctors and their teams in the field.
C) COCA does not provide resources to communities during disasters.
D) COCA does not provide expert advice to other nurses during natural disasters.
Page Ref: 2787
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Teamwork: Scope of practice, roles, and responsibilities of healthcare team members, including overlaps. | Nursing Process: Implementation
Learning Outcome: 46.A. Analyze emergency preparedness as it relates to healthcare systems. Outline the organizations responsible for emergency management and response.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

8) The nurse manager is discussing the preparedness phase of a revised emergency management plan for the emergency department. For which reason will the manager use The American Nurses Association (ANA) as a resource during an emergency response?

A) Explain the ethics of emergency response
B) Identify the procedure for working in a hot zone during a hazardous material incident
C) Examine the role of the incident commander in a disaster response
D) Provide the best means of communicating with agencies such as the Centers for Disease Control and Prevention (CDC) during a crisis

Answer: A

Explanation: A) During the preparedness phase, individual nurses must gain an understanding of their expected roles in an emergency and prepare for them. Because nurses will be required to allocate scarce resources and supplies and make unbelievably difficult client care decisions, they must understand the ethics associated with such choices. The ANA is a good source of information to guide nurses' understanding of their roles and possible consequences. Nurses must be aware of their employer's response plans and have a sense of how their state and local community will operate during an emergency.

B) The ANA is not a primary source of information for working in hot zones.

C) The ANA is not a primary source of information for understanding the role of the incident commander.

D) The ANA is not a primary source of information for understanding the best means of communicating with agencies such as the CDC.

Page Ref: 2793
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Teamwork: Scope of practice, roles, and responsibilities of healthcare team members, including overlaps. | Nursing Process: Planning
Learning Outcome: 46.A. Analyze emergency preparedness as it relates to healthcare systems. Outline the organizations responsible for emergency management and response.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

9) The nurse is responding in the aftermath of a hurricane. Hundreds of clients demand attention. The nurse will implement which plan to assess the priority of these clients?
A) Reverse triage
B) Standard emergency department triage
C) A disaster response plan
D) American Nurses Association (ANA) ethics rules
Answer: A
Explanation: A) Nurses perform triage every day in emergency departments. During a mass casualty event (more than 100 victims), the demand on nurses' knowledge and skills will be even greater. Mass casualty events call for the implementation of reverse triage, in which the most severely injured or ill victims who require the greatest resources are treated last to allow the greatest number of victims to receive medical attention.
B) Standard emergency department triage would not be used during a mass casualty event.
C) A disaster response plan involves the general response to an emergency.
D) The American Nurses Association (ANA) guides nurses in making ethical decisions but does not specifically address the means of prioritizing client needs in a disaster.
Page Ref: 2787-2788
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Teamwork: Scope of practice, roles, and responsibilities of healthcare team members, including overlaps. | Nursing Process: Assessment
Learning Outcome: 46.A. Analyze emergency preparedness as it relates to healthcare systems. Explain the role of nurses in emergency management and response.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

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10) A railway accident causes the release of a dangerous chemical compound into the atmosphere. The nurse providing rapid triage and emergency treatment for clients in an effort to stabilize them knows that which is the primary purpose of the warm zone in this incident?

A) Decontamination

B) Rapid triage

C) Reverse triage

D) Emergency medical treatment

Answer: A

Explanation: A) The warm zone (also referred to as the yellow, contamination, or contamination reduction zone) is located at least 300 feet from the outer edge of the hot zone. Although the primary purpose is decontamination, rapid triage and emergency treatment to stabilize victims may also take place in the warm zone. Individuals who have the highest levels of contamination are treated with the highest priority. Personal protective equipment (PPE) is required in this zone.

B) Rapid triage does not occur in the warm zone.

C) Reverse triage does not occur in the warm zone.

D) The warm zone is not primarily for emergency medical treatment.

Page Ref: 2790

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Teamwork: Scope of practice, roles, and responsibilities of healthcare team members, including overlaps. | Nursing Process: Planning

Learning Outcome: 46.A. Analyze emergency preparedness as it relates to healthcare systems. Describe the safety zones used in site-specific disaster response.

MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

11) Terrorists have detonated a bomb in the downtown area of a major city, destroying part of a hotel, damaging nearby buildings, and killing or injuring an unknown number of people. A nurse in an emergency department handling many clients injured in the explosion receives a phone call from the babysitter for her children aged 5, 6, and 9, who says she's been watching the event unfold on TV since it happened. The nurse's family lives in a suburb more than 20 miles from the downtown. Which response should the nurse make?

A) "Explain to the children that the people who did this are sick and will be punished for what they've done."

B) "Please continue to watch the TV coverage with my kids in the room to ensure that you know what's going on at all times."

C) "Please tell my children I'm alright but turn off the television and play a game with them to get them thinking about something else."

D) "If you plan to continue to watch the TV coverage, please do it on the TV in my bedroom away from the kids."

Answer: C

Explanation: A) Trying to explain the tragedy in terms of crime and punishment is not appropriate.

B) Continuing to watch the news nonstop is not appropriate.

C) Limit the amount of media and news coverage children are exposed to, as this can be frightening to younger children. In this case, it would be best for the babysitter to engage the children in play that does not involve obsessively watching the news.

D) Watching the TV away from the children is not appropriate.

Page Ref: 2792

Cognitive Level: Applying

Client Need/Sub: Psychosocial Integrity

Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Scope of practice, roles, and responsibilities of healthcare team members, including overlaps. | Nursing Process: Implementation

Learning Outcome: 46.A. Analyze emergency preparedness as it relates to healthcare systems. Analyze the importance of collaboration during disaster response.

MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

12) The detonation of several incendiary devices in a suburban area has caused widespread fires. A nursing home nearest one of the largest fires needs to be evacuated. Which concern would be the greatest for the nursing staff providing care in this facility?
A) Socioeconomic limitations
B) Diminished sensory awareness
C) Inadequate thermoregulation mechanisms
D) Limited mobility
Answer: D
Explanation: A) Socioeconomic limitations would not be the greatest concern.
B) Diminished sensory awareness would not be the greatest concern.
C) Inadequate thermoregulation mechanisms are not the greatest concern.
D) The primary issue that should concern the nurses in this situation is the clients' limited mobility. They need to evacuate and doing so quickly could be difficult for many of the clients.
Page Ref: 2792
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Teamwork: Apply evidence to support decision making in situations characterized by ambiguity and uncertainty. | Nursing Process: Planning
Learning Outcome: 46.A. Analyze emergency preparedness as it relates to healthcare systems. Explain the role of nurses in emergency management and response.
MNL LO: Analyze the concept of healthcare systems and its application to nursing care.

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Module 47 Health Policy

The Concept of Health Policy

1) A local health system implemented a number of health promotion policies and plans to prioritize health problems. The system must now evaluate the effectiveness of the interventions. Which groups are stakeholders in this initiative and would be involved in the evaluation process?
A) Only consumers who were directly affected by the services provided
B) Consumers, community leaders, and politicians
C) Only hospital and clinic personnel who administered healthcare needs
D) Healthcare providers employed by other health systems
Answer: B
Explanation: A) Consumers are part of the process but would not be the only evaluation group.
B) Community leaders, politicians, and consumers all would be stakeholders and would be included in the evaluation process.
C) Because policy changes are made by the health system, the hospital and clinic personnel employed there would not evaluate the effectiveness of policy without participation by the community.
D) Healthcare providers employed by other health systems would not be stakeholders in this initiative and would not need to be included in the evaluation process.
Page Ref: 2797
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 7.1 Apply knowledge of systems to work effectively across the continuum of care. | NLN Competencies: Context and Environment: Read and interpret data; apply health promotion/disease prevention strategies. | Nursing Process: Evaluation
Learning Outcome: 47.2. Summarize the process of developing health policies.
MNL LO: Analyze the concept of health policy and its application to nursing care.

2) Which types of programs can receive accreditation from the National League of Nursing (NLN)? **Select all that apply.**
A) Bachelor of Science in Nursing (BSN) programs
B) Licensed Vocational Nursing (LVN) programs
C) Medical Assisting programs
D) Licensed Practical Nursing (LPN) programs
E) Dental Assisting programs
Answer: A, B, D
Explanation: A) The NLN accredits nursing programs at all levels, including BSN programs.
B) The NLN accredits nursing programs at all levels, including LVN programs.
C) Medical Assisting programs would not be eligible for NLN accreditation.
D) The NLN accredits nursing programs at all levels, including LPN programs.
E) Dental Assisting programs would not be eligible for NLN accreditation.
Page Ref: 2801
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 9.4 Comply with relevant laws, policies, and regulations. | NLN Competencies: Context and Environment: Codes of ethics, regulatory and professional standards, ethical decision-making models; Scope of practice considerations; Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Implementation
Learning Outcome: 47.5. Analyze the role of accrediting organizations in the advancement of health policy.

MNL LO: Analyze the concept of health policy and its application to nursing care.

3) A nursing student would like to learn more about developing professional behavior. Which action should the student take in order to access information that may be useful in developing professional demeanor?
A) Join the America Nurses Association (ANA).
B) Join the National Student Nurses Association (NSNA).
C) Read the Nurse Practice Act.
D) Use the Internet to obtain information.
Answer: B
Explanation: A) The ANA is for members practicing nursing, not students, although students may join.
B) The NSNA is an organization specifically for student nurses with a goal of assisting the student to foster their professional development.
C) Nurse practice acts do need to be read by students, but they denote laws, not professionalism.
D) The Internet is good for obtaining information and for networking but is not necessarily a help to the student who wishes to increase professionalism.
Page Ref: 2801
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of health care team members. | AACN Domains and Competencies: 9.3 Demonstrate accountability to the individual, society, and the profession. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards, ethical decision-making models. | Nursing Process: Implementation
Learning Outcome: 47.6. Analyze professional organizations' influences on health policy.
MNL LO: Analyze the concept of health policy and its application to nursing care.

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4) An older adult client experiences an extended hospitalization due to a chronic illness. The client states to the nurse, "I don't know how I can pay for this hospital stay and afford all of the new medication that I have been prescribed." Which response by the nurse is the most appropriate?
A) "I'll have someone from the business office come and talk to you about your bill."
B) "You need to focus on recovering and stop worrying about money."
C) "Much of your care will be covered by Medicare."
D) "Don't worry. I'm sure everything will work out okay."
Answer: C
Explanation: A) Giving the concern to the business office is merely "passing the buck."
B) Ignoring the client's concerns by telling him not to worry is not therapeutic communication and does little, if anything, to confront the client's concerns.
C) Medicare is a federally funded health insurance program for individuals age 65 and older. Coverage can include hospital, medical, and pharmacy costs.
D) Ignoring the client's concerns by telling him not to worry is not therapeutic communication.
Page Ref: 2804-2805
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.9. Assess level of patient's decisional conflict and provide access to resources. | AACN Domains and Competencies: 2.2 Communicate effectively with individuals. | NLN Competencies: Relationship Centered Care: Communicate information effectively; Listen openly and cooperatively. | Nursing Process: Implementation
Learning Outcome: 47.7. Analyze types of health insurance and the health policies that regulate reimbursement.

MNL LO: Analyze the concept of health policy and its application to nursing care.

5) A student nurse will be attending clinicals at the local health department. When preparing for the clinical experience, the student researches programs offered by health departments. Which programs did the student most likely find during the research? **Select all that apply.**
A) Injury prevention campaigns
B) Lead poisoning prevention efforts
C) Nutritional programs
D) Disease monitoring efforts
E) Workplace safety inspections
Answer: A, B, C, D
Explanation: A) Local health departments oversee a variety of health policies and the respective regulations. Typical programs include injury prevention campaigns.
B) Local health departments oversee a variety of health policies and the respective regulations. Typical programs include lead poisoning prevention efforts.
C) Local departments of health usually administer the Women, Infants, and Children (WIC) supplemental nutrition program.
D) Local health departments are often responsible for developing and enforcing city-wide health codes and for disease monitoring.
E) The Occupational Safety and Health Administration (OSHA) is a federal agency that works to ensure the health and safety of Americans in the workplace.
Page Ref: 2799
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: V.A.7. Discuss potential and actual impact of national patient safety resources, initiatives, and regulations. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: Code of Ethics; Regulatory and professional standards. | Nursing Process: Implementation

Learning Outcome: 47.4. Outline the agencies or organizations involved in oversight or influence of health policy.
MNL LO: Analyze the concept of health policy and its application to nursing care.

6) Which regulatory agency ensures the health and safety of Americans in the workplace?
A) Department of Health and Human Services (DHHS)
B) National Institutes of Health (NIH)
C) Occupational Safety and Health Administration (OSHA)
D) Centers for Medicare and Medicaid Services (CMS)
Answer: C
Explanation: A) The DHHS is the federal government's principal agency for the protection of the health of all Americans and the provision of essential human services for those least able to care for themselves.
B) The NIH is a branch of the DHHS that is responsible for health research and the provision of health-related information.
C) OSHA works to ensure the health and safety of Americans in the workplace.
D) The CMS is responsible for healthcare financing.
Page Ref: 2798
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Code of Ethics; Regulatory and professional standards. | Nursing Process: Planning
Learning Outcome: 47.4. Outline the agencies or organizations involved in oversight or influence of health policy.
MNL LO: Analyze the concept of health policy and its application to nursing care.

7) Which organization promotes excellence in all levels of nursing education?
A) National League for Nursing (NLN)
B) National Student Nurses Association (NSNA)
C) American Nurses Association (ANA)
D) American Association of Colleges of Nursing (AACN)
Answer: A
Explanation: A) Part of the mission of the NLN is to promote excellence in nursing education to build a strong and diverse nursing workforce.
B) The NSNA is a nonprofit organization that mentors nursing students who are preparing for initial licensing as a registered nurse.
C) The ANA fosters high standards of nursing practice, promotes the rights of nurses in the workplace, projects a positive and realistic view of nursing, and lobbies Congress and regulatory agencies on healthcare issues affecting nurses and the public.
D) The AACN is the national voice for America's baccalaureate and graduate nursing education programs.
Page Ref: 2801
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 9.4 Comply with relevant laws, policies, and regulations. | NLN Competencies: Knowledge and Science: Integration of knowledge from nursing and other disciplines. | Nursing Process: Assessment
Learning Outcome: 47.6. Analyze professional organizations' influences on health policy.
MNL LO: Analyze the concept of health policy and its application to nursing care.

8) When a law related to public health policy is passed, which type of agency of the federal or state government is responsible for administering it?
A) A local branch agency
B) A legislative branch agency
C) An executive branch agency
D) A judicial branch agency
Answer: C
Explanation: A) Local agencies do not have this responsibility.
B) Legislative branch agencies are not involved in this area.
C) Once a law related to health policy has been passed, an executive branch agency of the federal or state government, such as the Centers for Disease Control and Prevention (CDC), is responsible for administering it.
D) Judicial branch agencies are not involved in this area.
Page Ref: 2796
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 9.4 Comply with relevant laws, policies, and regulations. | NLN Competencies: Context and Environment: Code of Ethics; regulatory and professional standards. | Nursing Process: Assessment
Learning Outcome: 47.1. Describe health policy, as an entity and as a process.
MNL LO: Analyze the concept of health policy and its application to nursing care.

9) Which action can a nursing student take to comply with nurse practice acts and remain accountable for knowing the legal nursing scope of practice in their state?
A) Become engaged in organizational quality improvement projects.
B) Obtain current licensure.
C) Join the American Nurses Association (ANA).
D) Become accredited.
Answer: B
Explanation: A) Participation in quality improvement projects will not help the student know the legal nursing scope of practice.
B) Current licensure is required for practice as a nurse as part of the nurse practice acts. Through licensure, nurses are held accountable for knowing the legal nursing scope of practice in their state and what actions could place their licensure status in jeopardy, as well as all regulations that accompany the nurse practice act.
C) Nurse practice acts do not require membership in the ANA.
D) Healthcare organizations, not nurses, can become accredited.
Page Ref: 2798
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 9.4 Comply with relevant laws, policies, and regulations. | NLN Competencies: Context and Environment: Codes of ethics, regulatory and professional standards, ethical decision-making models; Scope of practice considerations; Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Implementation

Learning Outcome: 47.3. Outline the relationship between health policy and other concepts.
MNL LO: Analyze the concept of health policy and its application to nursing care.

10) The nurse is working for a healthcare organization that is going through the reaccreditation process. Which action can the nurse take to help the organization be successful in the reaccreditation process?
A) Write position statements related to current events that affect the nursing profession.
B) Influence change by working with public officials at the local, community, state, and national levels.
C) Understand how healthcare policy affects patients, their own practice, and their organization.
D) Facilitate the use of nursing procedures that are current and evidence-based.
Answer: D
Explanation: A) Writing position statements is a responsibility of the ANA Board of Directors.
B) Although working with public officials is an important role of nurses related to health policy, they do not directly affect accreditation.
C) Although understanding healthcare policy is an important role of nurses related to health policy, they do not directly affect accreditation.
D) The nurse's role in The Joint Commission accreditation process may include helping to develop, revise, or facilitate use of policies and procedures for nursing practice that are current and evidence-based.
Page Ref: 2800
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: III.B.6. Participate in structuring the work environment to facilitate integration of new evidence into standards of practice. | AACN Domains and Competencies: 9.4 Comply with relevant laws, policies, and regulations. | NLN Competencies: Knowledge and Science: Evidence and best practices for nursing. | Nursing Process: Implementation
Learning Outcome: 47.5. Analyze the role of accrediting organizations in the advancement of health policy.
MNL LO: Analyze the concept of health policy and its application to nursing care.

11) Which type of health insurance plan requires the participant to select a primary care provider?
A) Health maintenance organization (HMO)
B) Preferred-provider organization (PPO)
C) Point-of-service (POS)
D) Indemnity
Answer: A
Explanation: A) Of the four main types of private health insurance plans, the only one that requires the participant to select a primary care provider is the health maintenance organization (HMO) plan.
B) A PPO does not require the participant to select a primary care provider.
C) A POS structure does not require the participant to select a primary care provider.
D) An indemnity insurance plan does not require the participant to select a primary care provider.
Page Ref: 2803
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 9.4 Comply with relevant laws, policies, and regulations. | NLN Competencies: Context and Environment: Environmental health; Health promotion/disease prevention (e.g., transmission of disease, disease patterns, epidemiological principles); Chronic disease management; Healthcare systems; Transcultural approaches to health; Family dynamics. | Nursing Process: Planning
Learning Outcome: 47.7. Analyze types of health insurance and the health policies that regulate reimbursement.
MNL LO: Analyze the concept of health policy and its application to nursing care.

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Module 48 Informatics

The Concept of Informatics

1) The nurse is documenting in the electronic medical record (EMR) after providing care in the client's room. The client asks the nurse why a computer is being used. Which response by the nurse is appropriate?
A) "The information that is uploaded is available for anyone to view."
B) "Computers improve client care because information is readily available."
C) "The computer decreases documentation time for nurses."
D) "Computers allow you access to your medical record."
Answer: B
Explanation: A) The client's information is protected by privacy laws.
B) Nursing informatics is the science of using computers in nursing practice to improve client care by making client information easily accessible for the client and other healthcare workers who are participating in the client's care.
C) Documenting client information by computer does not necessarily reduce charting time, depending on the system used.
D) Clients have the right to access their medical records regardless of whether they are paper or electronic.
Page Ref: 2809
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: VI.A.1. Explain why information and technology skills are essential for safe patient care. | AACN Domains and Competencies: 8.1 Describe the various information and communication technology tools used in the care of patients, communities, and populations. | NLN Competencies: Quality and Safety: Carefully maintain and use electronic and/or written health records. | Nursing Process: Implementation
Learning Outcome: 48.3. Explain the use of informatics in healthcare.
MNL LO: Analyze the concept of informatics and its application to nursing care.

2) The nurse is part of the clinical information system committee at a major healthcare organization. When designing a plan to ensure the protection of client information, which approaches should the nurse suggest this committee include in the implementation plan? **Select all that apply.**

A) Design policies to address password protection and login information.

B) Determine how to handle clients who desire to "friend" staff through social media.

C) Identify applications that interface with smartphones.

D) Create interfaces so that health data can be inputted by the client.

E) Teach users to not leave protected health information unattended.

Answer: A, B, E

Explanation: A) The committee is creating a plan to ensure the protection of client information. The committee needs to design polices for password protection and login information.

B) The committee is creating a plan to ensure the protection of client information. The committee needs to determine mechanisms to handle clients and staff who communicate through social media.

C) Identifying applications that interface with smartphones is not an approach to ensure the protection of client information.

D) Creating interfaces so that clients can input health data is not an approach to ensure the protection of client information.

E) The committee is creating a plan to ensure the protection of client information. The committee needs to teach users to not leave protected health information unattended.

Page Ref: 2810

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Management of Care

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Standards: QSEN Competencies: VI.C.3. Protect confidentiality of protected health information in electronic health records. | AACN Domains and Competencies: 8.5 Use information and communication technologies in accordance with ethical, legal, professional, and regulatory standards, and workplace policies in the delivery of care. | NLN Competencies: Knowledge and Science: Document via electronic health records; Use software applications related to nursing practice. | Nursing Process: Planning

Learning Outcome: 48.4. Analyze the uses of computerized medical records.

MNL LO: Analyze the concept of informatics and its application to nursing care.

3) The nurse is preparing discharge instructions for a client with a foot wound. In which way will the clinical information system support this client's learning needs?
A) Improves documentation about the client's status
B) Summarizes the list of charges that will appear on the client's bill
C) Provides a record of all medications received while hospitalized
D) Prints discharge instructions to use for teaching
Answer: D
Explanation: A) Improving documentation about the client's status will not support the client's learning needs.
B) Summarizing the charges on the client's bill will not support the client's learning needs.
C) Providing a list of all medications given to the client while hospitalized will not support the client's learning needs.
D) The clinical information system provides access to client information and provides data to help the nurse execute the nursing process. This includes printing discharge instructions to use in client teaching.
Page Ref: 2809
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.A.4. Describe examples of how technology and information management are related to the quality and safety of patient care. | AACN Domains and Competencies: 8.4 Use information and communication technology to support documentation of care and communication among providers, patients, and all system levels. | NLN Competencies: Knowledge and Science: Document via electronic health records; Use software applications related to nursing practice. | Nursing Process: Implementation
Learning Outcome: 48.3. Explain the use of informatics in healthcare.
MNL LO: Analyze the concept of informatics and its application to nursing care.

4) A rural home health nurse is caring for a client recovering from a myocardial infarction. The client is concerned that the community clinic does not have the ability to provide the necessary monitoring for the health problem. Which response by the nurse supports the use of informatics to meet client needs?
A) "It is not necessary for you to be monitored after a myocardial infarction."
B) "We can send your information to the cardiologist using telehealth."
C) "You are right. We will be sending you to the city every month."
D) "We use an intranet in this facility."
Answer: B
Explanation: A) A client who has experienced a myocardial infarction does require monitoring.
B) Through telehealth advances, clients who live in remote areas can have their information monitored by specialists using computers.
C) Because of this technology, clients do not need to make frequent visits to specialists for monitoring and evaluation of progress.
D) The intranet is used within an agency or system and is not a tool that can be accessed from the outside.
Page Ref: 2813
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.B.5. Employ communication technologies to coordinate care for patients. | AACN Domains and Competencies: 8.3 Use information and communication technologies and informatics processes to deliver safe nursing care to diverse populations in a variety of settings. | NLN Competencies: Quality & Safety: Tools for effective and open communication. | Nursing Process: Implementation
Learning Outcome: 48.5. Analyze the use of informatics for telehealth.
MNL LO: Analyze the concept of informatics and its application to nursing care.

5) The nurse is preparing an educational brochure to teach clients how to determine the validity of content obtained from health-related internet websites. Which information should the nurse include in this teaching tool? **Select all that apply.**

A) Source for the information
B) Sponsor of the website
C) Ways to identify if the site is selling a product
D) Number of visitors to the website
E) Date the content was last reviewed

Answer: A, B, C, E

Explanation: A) When analyzing online information, the source of the information should be validated.
B) The sponsor of the website should be clearly identified.
C) The site should be studied to see if a product is being sold.
D) It is not necessary to locate the number of visitors to the website.
E) A date when the data was last reviewed or updated should be visible.

Page Ref: 2815
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.B.8. Use high quality electronic sources of healthcare information. | AACN Domains and Competencies: 8.2 Use information and communication technology to gather data, create information, and generate knowledge. | NLN Competencies: Knowledge and Science: Retrieve research findings and other sources of information. | Nursing Process: Planning
Learning Outcome: 48.7. Analyze the use of the internet for patient education and e-health.
MNL LO: Analyze the concept of informatics and its application to nursing care.

6) A client diagnosed with cancer is receiving care through a facility that is 100 miles from the client's home. After the nurse explains how telehealth will be used to enhance this client's care, which client statements indicate that teaching about telehealth has been effective? **Select all that apply.**

A) "I will have to move closer to the provider."
B) "My health record can stay where I am."
C) "I can participate in the videoconference."
D) "I will have to change doctors."
E) "This will help lower some costs of care."

Answer: B, C, E

Explanation: A) Using telehealth, the client can live and stay in the home and does not need to move closer to the treatment or monitoring facility.
B) Telehealth allows for the client to keep health records in the home agency.
C) Telehealth allows for the client to participate in a videoconference.
D) The client will not be required to change healthcare providers.
E) Telehealth lowers many of the costs that could be incurred with frequent travel.

Page Ref: 2813
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.A.4. Describe examples of how technology and information management are related to the quality and safety of patient care. | AACN Domains and Competencies: 8.3 Use information and communication technologies and informatics processes to deliver safe nursing care to diverse populations in a variety of settings. | NLN Competencies: Quality & Safety: Tools for effective and open communication. | Nursing Process: Evaluation
Learning Outcome: 48.5. Analyze the use of informatics for telehealth.
MNL LO: Analyze the concept of informatics and its application to nursing care.

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7) Which action by the nurse will help minimize the risk of eyestrain when engaging in computerized documentation?
A) Use a firm board to rest the palm.
B) Use an antiglare screen cover.
C) Obtain a paper chart for nursing documentation.
D) Use a lumbar support.
Answer: B
Explanation: A) A firm, flat board or hard surface to rest the palm is the best way to protect the wrist from injury.
B) An antiglare screen cover may decrease the eyestrain that the nurse is experiencing.
C) The nurse will not be allowed to chart on paper because the nursing documentation is electronic.
D) A lumbar support helps with appropriate body posture for the back.
Page Ref: 2817
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.4. Value nurses' involvement in design, selection, implementation, and evaluation of information technologies to support patient care. | AACN Domains and Competencies: 10.1 Demonstrate a commitment to personal health and well-being. | NLN Competencies: Quality & Safety: Use technologies that contribute to safety. | Nursing Process: Implementation
Learning Outcome: 48.8. Differentiate good ergonomics from poor ergonomics.
MNL LO: Analyze the concept of informatics and its application to nursing care.

8) A group of staff nurses is discussing the importance of uniform language within healthcare documentation. Which statement made by one of the nurses indicates an understanding of uniform language in healthcare documentation?
A) "Uniform language is useful only when communicating with other staff nurses."
B) "Uniform language is the consistent use of the same terminology among all providers."
C) "Uniform language decreases the value of nursing interventions in the eyes of other providers."
D) "HIPAA and HITECH are examples of uniform languages used by nurses."
Answer: B
Explanation: A) Uniform language is useful when communicating both with nurses and with providers from other disciplines.
B) Uniform language is the consistent use of the same terminology among providers, facilities, institutions, and organizations.
C) Uniform language can increase the visibility of nursing interventions and thus increase their value in the eyes of other providers.
D) NANDA, NIC, and NOC are examples of uniform languages used by nurses, not HIPAA and HITECH.
Page Ref: 2811
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.B.4. Document and plan patient care in an electronic health record. | AACN Domains and Competencies: 8.4 Use information and communication technology to support documentation of care and communication among providers, patients, and all system levels. | NLN Competencies: Knowledge and Science: Document via electronic health records; Use software applications related to nursing practice. | Nursing Process: Evaluation
Learning Outcome: 48.4. Analyze the uses of computerized medical records.
MNL LO: Analyze the concept of informatics and its application to nursing care.

9) Which organization specifically focuses on improving healthcare quality, safety, and outcomes through improving the use of information technology (IT) and systems?
A) Healthcare Information and Management Systems Society (HIMSS)
B) American Medical Informatics Association (AMIA)
C) Alliance for Nursing Informatics (ANI)
D) Technology Informatics Guiding Educational Reform (TIGER)
Answer: A
Explanation: A) HIMSS works to improve healthcare quality, safety, and outcomes through improving the use of IT and systems.
B) AMIA is dedicated to developing health informatics that support client care and teaching.
C) ANI supports information leadership, practice, education, policy, and research.
D) TIGER integrates technology and informatics competencies into nursing education and practice.
Page Ref: 2808
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.A.1. Explain why information and technology skills are essential for safe patient care. | AACN Domains and Competencies: 8.4 Use information and communication technology to support documentation of care and communication among providers, patients, and all system levels. | NLN Competencies: Quality & Safety: Informatics. | Nursing Process: Assessment
Learning Outcome: 48.1. Analyze informatics as a key component of nursing practice.
MNL LO: Analyze the concept of informatics and its application to nursing care.

10) For which reason are there electronic reminders in the electronic health record?
A) Help decrease the length of stay.
B) Increase client safety.
C) Document assessments.
D) Track quality metrics.
Answer: B
Explanation: A) Reminders do not decrease the length of stay.
B) The primary direct advantage of electronic reminders is that they help improve client safety, often by reminding nurses to use certain screening tools or complete certain assessments.
C) Electronic reminders don't actually help nurses document assessments.
D) Reminders do not track quality metrics.
Page Ref: 2810
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.2. Value technologies that support clinical decision-making, error prevention, and care coordination. | AACN Domains and Competencies: 8.1 Describe the various information and communication technology tools used in the care of patients, communities, and populations. | NLN Competencies: Quality & Safety: Use technologies that contribute to safety. | Nursing Process: Implementation
Learning Outcome: 48.2. Outline the relationship between informatics and other concepts.
MNL LO: Analyze the concept of informatics and its application to nursing care.

11) Under which circumstance would the use of a geographic information system (GIS) be beneficial for healthcare workers?
A) When sharing a traveling client's electronic health record (EHR) with an out-of-state provider
B) During a mass casualty incident
C) When tracking the sleep pattern of a client
D) During an influenza outbreak
Answer: D
Explanation: A) GIS is not typically used when sharing a traveling client's EHR with an out-of-state provider.
B) GIS is not typically used during a mass casualty incident.
C) Although sleep patterns can be tracked using GIS, GIS is more beneficial when comparing sleep patterns in different geographic regions rather than tracking sleep patterns of one individual client.
D) A GIS is used to map where infectious diseases are most likely to spread next so that adequate care can be provided.
Page Ref: 2814
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.A.3. Contrast benefits and limitations of different communication technologies and their impact on safety and quality. | AACN Domains and Competencies: 8.2 Use information and communication technology to gather data, create information, and generate knowledge. | NLN Competencies: Quality & Safety: Use technologies that contribute to safety. | Nursing Process: Evaluation
Learning Outcome: 48.6. Explain the use of geographic information systems.
MNL LO: Analyze the concept of informatics and its application to nursing care.

Exemplar 48.A Clinical Decision Support Systems

1) The nurse is caring for a client who has a condition that is not responding to standard interventions. In which way would accessing the clinical decision support system (CDSS) help with this client's care?
A) Provides evidence-based recommendations for care
B) Decreases the need to use critical thinking skills
C) Tells the nurse what the next step should be
D) Supports the nurse's "gut" instinct when providing care
Answer: A
Explanation: A) A CDSS uses a knowledge base and programmed rules, protocols, and guidelines developed using evidence-based guidelines to match against client data in the electronic health record (EHR) to deliver alerts or recommendations to the provider.
B) The nurse still needs to use critical thinking skills to determine the best approach for the individual client.
C) The system will not provide a definitive next step for care.
D) The CDSS may or may not support the nurse's "gut" instinct.
Page Ref: 2820
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.2. Value technologies that support clinical decision making, error prevention, and care coordination. | AACN Domains and Competencies: 8.1 Describe the various information and communication technology tools used in the care of patients, communities, and populations. | NLN Competencies: Quality & Safety: Use technologies that contribute to safety. | Nursing Process: Planning
Learning Outcome: 48.A. Analyze clinical decision support systems as they relate to informatics. Describe the role of uniform languages in clinical decision support systems.
MNL LO: Analyze the concept of informatics and its application to nursing care.

2) Which statement best describes how the use of a clinical decision support system can help the nurse plan care for a client with a particular condition?
A) Identify what was done on the previous admission.
B) Identify evidence-based guidelines for this client's condition.
C) Support the use of standardized nursing language during documentation.
D) Search the internet for information about surgical procedures.
Answer: B
Explanation: A) Although informatics can help the nurse find out what was done on the previous admission, this will not help the nurse plan care.
B) Nursing care should always be based on evidence-based guidelines, which the nurse can access through a clinical decision support system.
C) Although informatics can help the nurse use standardized language for documentation, this will not help the nurse plan care.
D) Although informatics can help the nurse search the internet for information about the surgical procedure, this will not help the nurse plan care.
Page Ref: 2820
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.2. Value technologies that support clinical decision-making, error prevention, and care coordination. | AACN Domains and Competencies: 8.2 Use information and communication technology to gather data, create information, and generate knowledge. | NLN Competencies: Quality & Safety: Use technologies that contribute to safety. | Nursing Process: Planning
Learning Outcome: 48.A. Analyze clinical decision support systems as they relate to informatics. Describe the use of computers in nursing research.
MNL LO: Analyze the concept of informatics and its application to nursing care.

3) The nurse on the hospital research committee is assigned the task of compiling information related to the therapeutic and side effects of a specific drug. Which statement describes how the nurse can use informatics to gain information about this topic?

A) Search for articles about the drug in the hospital's library.

B) Email other research committees to find out what they know about the drug.

C) Query electronic health records (EHRs) to determine client responses to the drug.

D) Look up the drug facts in the latest pharmacology textbook.

Answer: C

Explanation: A) Searching for articles in the library does not require the use of informatics.

B) Although emailing does use computers, emailing another research committee for information about a drug is not best practice for nursing research.

C) Using computers, nurses can now query EHRs to research client responses to drug administration.

D) Looking up drug facts in a textbook does not require the use of informatics.

Page Ref: 2818

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: VI.B.8. Use high quality electronic sources of healthcare information. | AACN Domains and Competencies: 8.2 Use information and communication technology to gather data, create information, and generate knowledge. | NLN Competencies: Knowledge and Science: Retrieve research findings and other sources of information. | Nursing Process: Implementation

Learning Outcome: 48.A. Analyze clinical decision support systems as they relate to informatics. Describe the use of computers in nursing research.

MNL LO: Analyze the concept of informatics and its application to nursing care.

4) The nurse is facing a problem with a long-term care client that is different from anything encountered by the nurse in the past. Which nursing action is appropriate prior to taking the problem to the research committee?
A) Perform a review of the literature.
B) Ask the client's family if this is a recurring issue.
C) Bring the problem up for discussion in the next staff meeting.
D) Ask the physician for assistance.
Answer: A
Explanation: A) When encountering a problem, the nurse can conduct a literature review to find applicable information.
B) Asking the client's family if the problem is recurring will not help the nurse determine the course of care.
C) A staff meeting may provide some other opinions but will not give the nurse information regarding studies related to the client's problem.
D) The physician is not consulted for nursing problems.
Page Ref: 2818
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.B.8. Use high quality electronic sources of healthcare information. | AACN Domains and Competencies: 8.2 Use information and communication technology to gather data, create information, and generate knowledge. | NLN Competencies: Knowledge and Science: Retrieve research findings and other sources of information. | Nursing Process: Planning
Learning Outcome: 48.A. Analyze clinical decision support systems as they relate to informatics. Describe the use of computers in nursing research.
MNL LO: Analyze the concept of informatics and its application to nursing care.

5) In preparation for the next quality improvement committee meeting, the nurse accesses the clinical decision support system to run an outcomes report. In which way should the nurse anticipate the committee using this report?

A) Eliminate unnecessary care
B) Measure the length of hospital stays
C) Assist in modifying policies and procedures
D) Validate appropriate place of treatment

Answer: C

Explanation: A) Utilization review is designed to eliminate inappropriate or unnecessary medical care. This would not be the focus of a quality improvement committee meeting.

B) Utilization review focuses on length of stay. This would not be the focus of a quality improvement committee meeting.

C) Outcome tracking helps identify faulty processes and assists in modifying policies and procedures to improve client outcomes for a particular diagnosis or department within a health organization.

D) Utilization review validates appropriate place of treatment. This would not be the focus of a quality improvement committee meeting.

Page Ref: 2819

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: VI.A.4. Describe examples of how technology and information management are related to the quality and safety of patient care. | AACN Domains and Competencies: 8.1 Describe the various information and communication technology tools used in the care of patients, communities, and populations. | NLN Competencies: Quality & Safety: Contribute to assessment of outcome achievement. | Nursing Process: Implementation

Learning Outcome: 48.A. Analyze clinical decision support systems as they relate to informatics. Describe the use of computers in nursing administration.

MNL LO: Analyze the concept of informatics and its application to nursing care.

6) In which way does the clinical decision support system support human resource functions?
A) Determining if staff are correctly coding client care procedures
B) Identifying staff who are incorrectly charging for resources used for client care
C) Recognizing staff who are not discharging clients according to identified lengths of stay
D) Evaluating the number of staff with licensure due to expire
Answer: D
Explanation: A) Coding would be used by the billing department.
B) Charging for resources would be used by the billing department.
C) Information about client discharges according to identified lengths of stay would be used in a utilization review.
D) Human resource departments can benefit from computerization by tracking personnel within the healthcare system. Professional licenses and credentials expire and must be renewed. It would be a daunting task to keep track of this information manually for a large facility that employs thousands of healthcare professionals. A computerized system can monitor license expiration and when recredentialing of a provider is required.
Page Ref: 2818
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.A.4. Describe examples of how technology and information management are related to the quality and safety of patient care. | AACN Domains and Competencies: 8.5 Use information and communication technologies in accordance with ethical, legal, professional, and regulatory standards, and workplace policies in the delivery of care. | NLN Competencies: Quality & Safety: Informatics. | Nursing Process: Implementation
Learning Outcome: 48.A. Analyze clinical decision support systems as they relate to informatics. Describe the use of computers in nursing administration.
MNL LO: Analyze the concept of informatics and its application to nursing care.

7) The nurse administrator of a local hospital is attending training on the new informatics system the hospital will be implementing. Which information should the nurse administrator be able to manage from the dashboard? **Select all that apply.**
A) Staffing
B) Budgets
C) Clients
D) Quality initiatives
E) Plans of care
Answer: A, B, D
Explanation: A) Many electronic health records give administrators tools to manage staffing.
B) Many electronic health records give administrators tools to manage budgets.
C) The dashboard does not include client-specific information.
D) Many electronic health records give administrators tools to manage quality initiatives.
E) The dashboard does not include client-specific plans of care.
Page Ref: 2818
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.A.4. Describe examples of how technology and information management are related to the quality and safety of patient care. | AACN Domains and Competencies: 8.2 Use information and communication technology to gather data, create information, and generate knowledge. | NLN Competencies: Quality & Safety: Informatics. | Nursing Process: Implementation
Learning Outcome: 48.A. Analyze clinical decision support systems as they relate to informatics. Describe the use of computers in nursing administration.
MNL LO: Analyze the concept of informatics and its application to nursing care.

8) Which factor increases nurses' use of clinical decision support systems (CDSS)?
A) Out-of-the-way workstations
B) Nursing experience
C) Manage medications
D) Reminder pop-ups
Answer: C
Explanation: A) nurses tend to decrease use of a CDSS when the workstation is not conveniently located.
B) Nurses tend to decrease use of a CDSS when they have more nursing experience.
C) Nurses tend to use CDSS more frequently when they are managing medications for a client.
D) Nurses tend to decrease use of a CDSS when there are too many reminders.
Page Ref: 2818
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.2. Value technologies that support clinical decision-making, error prevention, and care coordination. | AACN Domains and Competencies: 8.1 Describe the various information and communication technology tools used in the care of patients, communities, and populations. | NLN Competencies: Quality & Safety: Use technologies that contribute to safety. | Nursing Process: Implementation
Learning Outcome: 48.A. Analyze clinical decision support systems as they relate to informatics. Describe the use of computers in nursing administration.
MNL LO: Analyze the concept of informatics and its application to nursing care.

9) Which administrative function related to medical records management may be made easier by the use of informatics?
A) Tracking client outcomes
B) Making sure charts are coded correctly
C) Ordering materials and supplies
D) Assigning a client to a hospital room
Answer: D
Explanation: A) Tracking client outcomes is part of quality assurance.
B) Making sure charts are coded correctly is the job of the billing department.
C) Ordering materials and supplies is related to facilities management.
D) Assigning a client to a hospital room is related to medical records management.
Page Ref: 2818
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.A.4. Describe examples of how technology and information management are related to the quality and safety of patient care. | AACN Domains and Competencies: 8.5 Use information and communication technologies in accordance with ethical, legal, professional, and regulatory standards, and workplace policies in the delivery of care. | NLN Competencies: Quality & Safety: Informatics. | Nursing Process: Implementation
Learning Outcome: 48.A. Analyze clinical decision support systems as they relate to informatics. Describe the use of computers in nursing administration.
MNL LO: Analyze the concept of informatics and its application to nursing care.

10) Which function might be made easier for healthcare organizations through the use of a computerized contract management system?
A) Tracking changes in reimbursement rates
B) Sharing information between billing systems
C) Managing material and supply inventories
D) Planning organizational budgets
Answer: A
Explanation: A) A computerized contract management system helps facilities track rates of reimbursement and real-time changes in policies for different health insurance plans.
B) Financial systems help share information between billing systems.
C) Financial systems manage material and supply inventories.
D) Financial systems help plan organizational budgets.
Page Ref: 2818-2819
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.A.5. Recognize the time, effort, and skill required for computers, databases and other technologies to become reliable and effective tools for patient care. | AACN Domains and Competencies: 8.4 Use information and communication technology to support documentation of care and communication among providers, patients, and all system levels. | NLN Competencies: Knowledge and Science: Document via electronic health records; Use software applications related to nursing practice. | Nursing Process: Implementation
Learning Outcome: 48.A. Analyze clinical decision support systems as they relate to informatics. Describe the use of computers in nursing administration.
MNL LO: Analyze the concept of informatics and its application to nursing care.

Exemplar 48.B Individual Information at Point of Care

1) Several nurses are discussing the use of electronic medical records when providing client care. Which statements by the nurses indicate that they understand the advantages of electronic health records (EHRs)? **Select all that apply.**
A) "The record reduces the cost of healthcare."
B) "The record allows trending of client progress."
C) "Client education can be documented in the system."
D) "Quality metrics can be observed to reduce readmission rates."
E) "Coordination of care is improved."
Answer: B, C, D, E
Explanation: A) The use of the electronic health record does not directly reduce the cost of healthcare.
B) Electronic health records can assist the nurse by allowing trending of client progress.
C) Electronic health records can assist the nurse by allowing documentation of client education.
D) Electronic health records can assist the nurse by allowing observation of quality metrics to help decrease readmission rates.
E) Electronic health records also allow improved coordination of care between providers because they are all working off one chart.
Page Ref: 2820
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.A.4. Describe examples of how technology and information management are related to the quality and safety of patient care. | AACN Domains and Competencies: 8.1 Describe the various information and communication technology tools used in the care of patients, communities, and populations. | NLN Competencies: Knowledge and Science: Document via electronic health records; Use software applications related to nursing practice. | Nursing Process: Evaluation
Learning Outcome: 48.B.2. Analyze individual information at point of care as it relates to informatics. Outline uses of computer-based patient records in community and hospital settings.
MNL LO: Analyze the concept of informatics and its application to nursing care.

2) The nurse is providing discharge instructions about medications and exercise to a client who was hospitalized with a serious medical condition. Which action by the nurse ensures that the client is fully informed?

A) Make sure a relative attends the discharge teaching session.

B) Repeat the discharge teaching sessions twice.

C) Ask the physician to reinforce teaching prior to discharging the client.

D) Print the discharge instructions and hand them to the client prior to discharge.

Answer: D

Explanation: A) Relatives can forget as easily as the client.

B) Repeating the instructions does not help the client at home.

C) It is not the physician's place to reinforce teaching.

D) Most hospitals and agencies have computer-generated discharge instructions that the nurse can print to give the client to refer to when at home. This not only prevents calls but gives the client confidence.

Page Ref: 2822

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: VI.A.4. Describe examples of how technology and information management are related to the quality and safety of patient care. | AACN Domains and Competencies: 8.4 Use information and communication technology to support documentation of care and communication among providers, patients, and all system levels. | NLN Competencies: Knowledge and Science: Document via electronic health records; Use software applications related to nursing practice. | Nursing Process: Implementation

Learning Outcome: 48.B. Analyze individual information at point of care as it relates to informatics. Outline uses of computer-based patient records in community and hospital settings.

MNL LO: Analyze the concept of informatics and its application to nursing care.

3) Which statement regarding the term "point of care" is correct?
A) "Point of care" refers to the use of a portable device to provide care near the client.
B) "Point of care" refers to the location that nurses document care of the client.
C) "Point of care" refers to care that takes place away from the client.
D) "Point of care" refers to care that takes place in the client's home.
Answer: A
Explanation: A) One of the selling points of an electronic health record is that charting at point of care is possible, which helps to increase efficiency. Point of care refers to interventions or testing that takes place using a transportable, portable, or handheld device near the client.
B) Point of care does not refer to the location where documentation takes place.
C) Point of care does not refer to the care that takes place away from the client.
D) Point of care does not refer to care that takes place in the client's home.
Page Ref: 2820
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.2. Value technologies that support clinical decision-making, error prevention, and care coordination. | AACN Domains and Competencies: 8.3 Use information and communication technologies and informatics processes to deliver safe nursing care to diverse populations in a variety of settings. | NLN Competencies: Knowledge and Science: Document via electronic health records; Use software applications related to nursing practice. | Nursing Process: Evaluation
Learning Outcome: 48.B. Analyze individual information at point of care as it relates to informatics. Summarize the advantages of point-of-care service delivery.
MNL LO: Analyze the concept of informatics and its application to nursing care.

4) Advances in technology have made what information available to healthcare providers at the client's bedside?
A) Vital signs
B) Radiologic images
C) Allergy alerts
D) Dietary restrictions
Answer: B
Explanation: A) Even before many advances in technology, nurses and other healthcare providers had access to the client's current vital signs.
B) With advances in technology, results from laboratory and radiologic exams can often be viewed at the client's bedside.
C) Even before many advances in technology, nurses and other healthcare providers had access to allergy alerts.
D) Even before many advances in technology, nurses and other healthcare providers had access to the client's dietary restrictions.
Page Ref: 2820
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.A.4. Describe examples of how technology and information management are related to the quality and safety of patient care. | AACN Domains and Competencies: 8.3 Use information and communication technologies and informatics processes to deliver safe nursing care to diverse populations in a variety of settings. | NLN Competencies: Context and Environment: Impact of continual knowledge explosion and constant evolution of technology. | Nursing Process: Evaluation

Learning Outcome: 48.B. Analyze individual information at point of care as it relates to informatics. Outline uses of computer-based patient records in community and hospital settings.
MNL LO: Analyze the concept of informatics and its application to nursing care.

5) Which statement explains an advantage of the standardization of health records in relation to client education?

A) It allows the nurse to print information for the client rather than reviewing the information in person.

B) Families can receive education rather than clients in order to ensure that the client receives proper care at home.

C) Clients can receive the same education about their condition regardless of where they receive treatment.

D) Clients can look up their health information at home after discharge.

Answer: C

Explanation: A) Standardization does not negate the nurse's responsibility to review the information in person with the patient or family.

B) Both families and client should receive education as appropriate, regardless of standardization.

C) Standardization of the health record allows clients to receive the same education about their condition regardless of where they receive treatment.

D) Clients looking up their health information at home does not depend on standardization of health records.

Page Ref: 2822

Cognitive Level: Understanding

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: VI.A.2. Identify essential information that must be available in a common database to support patient care. | AACN Domains and Competencies: 8.3 Use information and communication technologies and informatics processes to deliver safe nursing care to diverse populations in a variety of settings. | NLN Competencies: Context and Environment: Impact of continual knowledge explosion and constant evolution of technology. | Nursing Process: Implementation

Learning Outcome: 48.B. Analyze individual information at point of care as it relates to informatics. Outline uses of computer-based patient records in community and hospital settings.

MNL LO: Analyze the concept of informatics and its application to nursing care.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 49 Legal Issues

The Concept of Legal Issues

1) A student nurse administers a medication to the wrong client while the instructor is with another student. Which statement by the instructor is most appropriate in this situation?
A) "You have placed the nursing student program in danger."
B) "You may be sued by the hospital for the extra care cost to the client."
C) "You are expected to practice like a licensed nurse."
D) "You have set a bad example for the other students."
Answer: C
Explanation: A) It is not likely that the teaching program is in danger, as people do make mistakes and hospitals do rely on nursing schools to help provide care to clients.
B) Hospitals do not generally sue nurses to recover money for extended care due to an error.
C) A nursing student is held to the standard of conduct of an experienced, licensed professional nurse.
D) It is not likely that the other students are apt to follow the example of a student who fails to follow policy.
Page Ref: 2839
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards. | Nursing Process: Implementation
Learning Outcome: 49.2. Analyze tort law and its implication for nursing.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

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2) The nurse is concerned about being sued for negligence when providing care. Which actions may be grounds for negligence? **Select all that apply.**

A) Client fell getting out of bed because the call light was not used.
B) Client name band was checked prior to providing all medications.
C) Client's morning medications were administered in the early afternoon.
D) Client states not understanding activity restrictions and wound eviscerated.
E) Client documentation did not include appearance of infiltrated IV site.

Answer: A, C, D, E

Explanation: A) The client fell when getting out of bed because the call light was not used. Because there is no way of knowing if the client knew how to use the call light, the nurse should be concerned with this situation.

B) Checking the client name band before providing medications is not an action that is negligent.

C) Providing medications beyond the prescribed time can be viewed as negligent care.

D) Clear communication of directions, explanations, and providing effective client education regarding the client's healthcare requirements can help decrease the risk of bad outcomes, so the wound evisceration could be viewed as negligent care.

E) Poor documentation about care, wounds, and intravenous sites could be viewed as negligent care.

Page Ref: 2827
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Context and Environment: Codes of Ethics; regulatory and professional standards. | Nursing Process: Evaluation

Learning Outcome: 49.4. Outline strategies to prevent incidents of professional negligence.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

3) The nurse working on a medical-surgical unit wants to ensure care is provided within the standard of nursing care. Which actions by the nurse are appropriate? **Select all that apply.**

A) Analyze the position description.
B) Review and become familiar with the policy and procedure manual.
C) Question the value of collaborating with other disciplines.
D) Review the applicable state nurse practice act and administrative rules.
E) Adhere to national standards of practice and care.

Answer: A, B, D, E

Explanation: A) The nurse's specific job description will contribute to defining the standard of care.

B) Agency policies and procedures serve in defining the standard of care.

C) Nurses are expected to demonstrate competence within multiple areas of their professional role, including collaboration with the entire care team.

D) Employers can limit but not expand the scope of practice, and the nurse will be held to functioning within the scope of employment. The applicable state nurse practice act and administrative rules form the basis of the standard of care to which each nurse is held.

E) A primary source for defining the standard of care is the prevailing national nursing standards. Nurses who follow national standards of practice and standards of care will provide their clients with the best care possible and be far less likely to commit any unintentional act that may rise to the level of malpractice.

Page Ref: p, 2827

Cognitive Level: Evaluating

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Personal and Professional Development: Codes of ethics and regulatory and professional standards. | Nursing Process: Implementation

Learning Outcome: 49.5. Analyze the impact of the standard of care on legal issues.

MNL LO: Analyze the concept of legal issues and its application to nursing care.

4) The nurse observes a healthcare provider discussing an operative procedure with a client and determines that informed consent was achieved. Which information was included in the informed consent process? **Select all that apply.**
A) The provider's disapproval if the surgery is not performed
B) The health problem that requires surgery
C) The purpose of the surgery
D) The expectations of the surgery
E) Outcome if surgery is not performed
Answer: B, C, D, E
Explanation: A) To give informed consent voluntarily, the client must not be coerced in any manner. If the client provides consent due to fear of disapproval by a healthcare provider, such consent is not considered to be voluntary. Coercion of any kind invalidates the consent.
B) For informed consent to be achieved, the client should receive information about the diagnosis or condition that requires treatment.
C) For informed consent to be achieved, the client should receive information about the purpose of the surgery.
D) For informed consent to be achieved, the client should receive information about what the client can expect to feel and experience.
E) For informed consent to be achieved, the client should receive information about what could occur if the surgery is not performed or if alternatives to the treatment are chosen.
Page Ref: 2831
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.12. Facilitate informed patient consent for care. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Evaluation
Learning Outcome: 49.6. Outline laws that affect nursing practice.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

5) A client is receiving care in the hospital for life-threatening injuries sustained in a motor vehicle crash and is taken immediately to surgery. There is no family available to provide consent; however, the client's medical record is available and reviewed by the nurse. Which treatments are inappropriate in this situation? **Select all that apply.**

A) Emergency surgery
B) Treatment that was previously refused
C) Treatment that violates religious beliefs
D) Medications to treat the injury
E) Experimental medications for a research study

Answer: B, C, E

Explanation: A) In most states, the law assumes an individual's consent to medical treatment when the person is in imminent danger of loss of life or limb and unable to give informed consent. In other words, the emergency doctrine assumes that the individual would reasonably consent to treatment if able to do so. This doctrine serves as a guiding principle that permits healthcare providers to perform potentially life-saving procedures under circumstances that make it impossible or impractical to obtain consent.
B) Treatment that was previously refused is not appropriate.
C) Treatment that violates the client's documented religious beliefs is not appropriate.
D) Medication to treat injuries would be appropriate to give.
E) Experimental medications that are being initiated in conjunction with a research study are not appropriate.

Page Ref: 2832
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.B.12. Facilitate informed patient consent for care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Planning
Learning Outcome: 49.6. Outline laws that affect nursing practice.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

6) An adolescent client requests to be examined and receive counseling without parents being present. Which response demonstrates a correct response to this request?
A) The nurse asks the client's parents if this is okay with them.
B) The nurse agrees but still informs the parents immediately of everything they did not witness.
C) The nurse strongly urges the client to reconsider this request to receive the best possible care.
D) The nurse agrees that the client has the right to make this request but suggests that the parents still be present and involved.
Answer: D
Explanation: A) The nurse should not clear this request with the parents.
B) The nurse should not involve the parents anyway.
C) The nurse should not make it sound as though competent care depends on the adolescent reconsidering the request.
D) Adolescent clients may wish to be examined or receive counseling separate from their parents. The nurse should make every effort to honor this request, though doing so may lead to confrontation with the parents. Understanding state statutes and organizational policy related to adolescent confidentially is essential when situations such as this arise. When providing confidential care to adolescents, the nurse should encourage adolescents to consider involving parents or guardians in their decision making.
Page Ref: 2835
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Act in accordance with legal and regulatory requirements, including HIPAA, for faculty, students, patients, and families. | Nursing Process: Planning
Learning Outcome: 49.7. Differentiate considerations related to legal issues throughout the lifespan.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

7) Which action demonstrates correct reporting of suspected child abuse?
A) The nurse includes the entirety of the client's medical record.
B) The nurse compiles a report with all pertinent information that is factually true.
C) The nurse recommends that the organization report the abuse to state authorities.
D) The nurse reports only information the client has authorized for release.
Answer: B
Explanation: A) When abuse is reported, all pertinent information in the client's medical record (not simply the entire record) is required by law to be disclosed to the reporting agency.
B) Reports should be complete and accurate and should be made according to the policy of the organization for which the nurse works.
C) In addition to reporting the abuse within the organizational framework, the nurse should personally report the abuse to the proper authorities.
D) Reporting abuse or suspected abuse represents an exception to client confidentiality rules.
Page Ref: 2834
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Act in accordance with legal and regulatory requirements, including HIPAA, for faculty, students, patients, and families. | Nursing Process: Implementation
Learning Outcome: 49.7. Differentiate considerations related to legal issues throughout the lifespan.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

Exemplar 49.A Nurse Practice Acts

1) A client newly diagnosed with diabetes mellitus tells the nurse that the prescribed diet does not provide enough variation of choice. It is against the state's nurse practice act for a nurse to order a diet for the client. Which response by the nurse is most appropriate?
A) "I will bring you a different menu."
B) "I will ask my manager to talk with the dietitian."
C) "Let's look at your diet and see what type of variety we can find."
D) "I will notify the dietary department to change your diet."
Answer: C
Explanation: A) Providing the client with another menu will not help the client choose foods within the prescribed diet.
B) The nurse cannot enlist the assistance of a manager to change the diet without a healthcare provider prescription.
C) A nurse practice act (NPA) is a series of state statutes that define the scope of practice, standards for education programs, licensure requirements, and grounds for disciplinary actions. The law provides a framework for establishing nursing actions in the care of clients. It is against most states' nurse practice acts for the nurse to order a diet for the client. The nurse is allowed to assist the client to choose appropriate foods as ordered by the physician.
D) The nurse cannot notify the dietary department to change the diet without a healthcare provider prescription.
Page Ref: 2836
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Scope of practice considerations. | Nursing Process: Implementation
Learning Outcome: 49.A. Analyze nurse practice acts as they relate to legal issues. Explain how boards of nursing oversee licensure.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

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2) The nurse educator is teaching a group of nursing students about the function of the state board of nursing. Which information will the educator include in the teaching session? **Select all that apply.**

A) Creating the NCLEX-RN examination
B) Defining professional standards
C) Investigating violations of the nurse practice act
D) Suspending or revoking licenses
E) Finding drug treatment centers for impaired nurses

Answer: B, C, D

Explanation: A) The National Council for the State Boards of Nursing creates the NCLEX-RN examinations.
B) Boards of nursing oversee nursing licensure by defining professional standards.
C) Boards of nursing oversee nursing licensure by investigating violations of the nurse practice act.
D) Boards of nursing oversee nursing licensure by suspending or revoking licenses.
E) The state board of nursing is not responsible for finding treatment programs for drug-impaired nurses.

Page Ref: 2837
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Scope of practice considerations. | Nursing Process: Implementation
Learning Outcome: 49.A. Analyze nurse practice acts as they relate to legal issues. Explain how boards of nursing oversee licensure.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

3) The nurse receives a notice that the state board of nursing has become a member of the Nurse Licensure Compact. In which ways would this change in the state board of nursing structure influence the nurse's ability to practice nursing? **Select all that apply.**
A) The nurse can only practice nursing in the residing state.
B) The nurse can practice nursing in other states within the compact.
C) The nurse is accountable to the state in which the nurse practices and clients reside.
D) The nursing license will become similar to having a driver's license.
E) The nurse has to obtain an additional license.
Answer: B, C, D
Explanation: A) The mutual recognition model of nurse licensure does not mean that the nurse can only practice in the residing state.
B) The mutual recognition model of nurse licensure allows a nurse to have a single license that confers the privilege to practice in other states that are part of the Nurse Licensure Compact.
C) The nurse is held accountable for following the laws and rules of the state in which the nurse practices or where the client is located.
D) It is similar to the driver's license model: A single license to drive is issued in the state of primary residency, but this license also allows the privilege to drive in other compact states.
E) Multistate licensure privilege means the authority to practice nursing in another state that has signed an interstate compact. It is not an additional license.
Page Ref: 2938
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Scope of practice considerations. | Nursing Process: Implementation

Learning Outcome: 49.A. Analyze nurse practice acts as they relate to legal issues. Outline the Nurse Licensure Compact.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

4) The nursing instructor asks a student to explain why the American Board of Managed Care Nursing (ABMCN) is an example of a certification program. In which way should the student respond?
A) It formally recognizes nurses who have achieved a high standard of practice in managed care.
B) It provides a process for recognizing the professional competence of individuals who meet predetermined qualifications specified by the association or agency.
C) It investigates and adjudicates cases of professional negligence.
D) It lists the state requirements for a nursing professional to achieve licensure.
Answer: B
Explanation: A) Although a nursing license grants the legal privilege to practice, credentialing is the formal identification of professionals who meet predetermined standards of professional skill or competence. Formally recognizing nurses who have achieved a high standard of practice in managed care is an example of credentialing.
B) The federal government has used the term certification to define the credentialing process by which a nongovernmental agency or association recognizes the professional competence of an individual who has met certain predetermined qualifications specified by the agency or association. The American Board of Managed Care Nursing is one such organization.
C) It is not the ABMCN's role to investigate and adjudicate cases of professional negligence.
D) It is not the ABMCN's role to list requirements for nursing professionals to achieve licensure.
Page Ref: 2838
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Scope of practice considerations. | Nursing Process: Implementation
Learning Outcome: 49.A. Analyze nurse practice acts as they relate to legal issues. Differentiate credentialing and certification.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

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5) Which licensure examination was developed by the National Council of State Boards of Nursing (NCSBN) for state and territory boards of nursing (BONs) to implement as part of their requirements for licensure?
A) National Council Licensure Examination for Registered Nurses (NCLEX-RN)
B) National Nurse Aide Assessment Program (NNAAP)
C) Medication Aide Certification Examination (MACE)
D) Nursing Workforce Diversity (NWD) program
Answer: A
Explanation: A) The National Council of State Boards of Nursing (NCSBN) has developed two licensure examinations, the National Council Licensure Examination for Registered Nurses (NCLEX-RN) and the National Council Licensure Examination for Practical Nurses (NCLEX-PN), for state and territory BONs to implement as part of their requirements for licensure.
B) The NCSBN also offers the National Nurse Aide Assessment Program (NNAAP).
C) The NCSBN also offers the Medication Aide Certification Examination (MACE).
D) The Nursing Workforce Diversity (NWD) program is not a licensure examination.
Page Ref: 2837
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.7 Evaluate outcomes of care. | NLN Competencies: Context and Environment: Scope of practice considerations. | Nursing Process: Evaluation
Learning Outcome: 49.A. Analyze nurse practice acts as they relate to legal issues. Describe the National Council of State Boards of Nursing.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

6) Which statement exemplifies the ultimate accountability of nursing students for their actions?
A) "State regulatory bodies have the ultimate responsibility for my actions."
B) "The client's perception of the care I give determines the correctness of my actions."
C) "I am responsible for my own actions, correct or incorrect."
D) "No one may judge my actions as correct or incorrect other than me."
Answer: C
Explanation: A) State regulatory bodies are not responsible for the student's actions.
B) Client perception is not responsible for the student's actions.
C) Each nurse practice act (NPA) addresses the duties and responsibilities of nursing students in that state. This includes language that allows nursing students the privilege to practice nursing without a license while engaged in the clinical practicum of an approved nursing education program under the supervision of qualified faculty. Nursing students have the ultimate responsibility (accountability for their actions that includes the obligation to answer for an act done and to repair any injury one may have caused) for their own actions.
D) Responsibility does not mean that no one else but the nursing student may judge the student's actions.
Page Ref: 2839
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: II.A.2. Describe scopes of practice and roles of healthcare team members. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Scope of practice considerations. | Nursing Process: Implementation
Learning Outcome: 49.A. Analyze nurse practice acts as they relate to legal issues. Explain the duties and responsibilities of nursing students.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

Exemplar 49.B Advance Directives

1) A client with terminal cancer has signed an advance directive indicating that no parenteral nutrition or hydration will be implemented. For several days the client has refused food and fluids, pushing the caregiver's hands away when attempts are made to feed the client or offer any kind of fluid. The family is considering placing a gastrostomy tube because they feel the client is "starving to death." Which actions by the nurse are appropriate? **Select all that apply.**
A) Take the case to the hospital's ethics committee.
B) Honor the client's refusal of parenteral nutrition and hydration.
C) Talk to the healthcare provider so the family's wishes can be acted upon.
D) Help the family come to terms with the situation.
E) Honor the family's wishes and have them sign a consent form.
Answer: B, D
Explanation: A) An ethics committee is usually considered when there is an ethical dilemma, and more input is needed to make a decision.
B) The nurse is morally obligated to honor the refusal of food and fluids by a competent client who has signed an advance directive.
C) The physician may or may not be involved but would not disregard the client's refusal.
D) The nurse is obligated to help the family come to terms with the situation.
E) Clients, not their families, should make decisions about their own healthcare and treatment.
Page Ref: 2842
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Implementation
Learning Outcome: 49.B. Analyze advance directives as they relate to legal issues. Explain the role of the nurse in assisting families with advance directives.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

2) A client who sustained a traumatic brain injury several weeks ago is in a chronic vegetative state and is no longer competent to make healthcare decisions. Which person should the nurse expect to make care decisions for this client?

A) The physician
B) The client's spouse
C) Social services
D) The agent named in the durable power of attorney

Answer: D

Explanation: A) The physician is not the appropriate individual to make decisions for the client.

B) In the case of an incompetent client, the spouse would be the agent of the durable power of attorney only if the court appointed the spouse.

C) Social services may be the department that would contact the agent of a durable power of attorney, but social services would not be that power.

D) The nurse, recognizing that the client is no longer competent, should follow whatever hospital policy is in place for contacting the agent named in a durable power of attorney for healthcare.

Page Ref: 2840

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Planning

Learning Outcome: 49.B. Analyze advance directives as they relate to legal issues. Describe types of healthcare advance directives.

MNL LO: Analyze the concept of legal issues and its application to nursing care.

3) After discussing advance directives during a home visit, an older adult client decides to prepare documents for future care needs. Which actions by the nurse are appropriate in this situation? **Select all that apply.**
A) Telling the client that changes to the advance directive can be made at any time
B) Telling the client that it is not necessary to make decisions about healthcare needs in the future
C) Giving a copy of the advance directives to the client's adult children
D) Educating the client about the purpose and types of life-sustaining measures
E) Having the client name an individual to be responsible for care decisions
Answer: A, C, D
Explanation: A) The nurse should explain that if a decision is made on an advance directive, the decision can be changed.
B) An advance directive does not mean that the client does not need to make any future decisions about healthcare.
C) Clients should be instructed to provide a copy of their advance directives to their next of kin.
D) The nurse needs to assess whether the client has an accurate understanding of life-sustaining measures and provide teaching on these measures if necessary.
E) An individual to be responsible for care decisions is a durable power of attorney for healthcare and may or may not be included when creating an advance directive.
Page Ref: 2842
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Implementation
Learning Outcome: 49.B. Analyze advance directives as they relate to legal issues. Explain the role of the nurse in assisting families with advance directives.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

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4) The nurse educator on an oncology unit is teaching staff nurses about advance directives. Which elements will the nurse include in the teaching session? **Select all that apply.**
A) The surrogate decision maker has the authority to consent to any medical treatment or diagnostic procedure.
B) The surrogate decision maker has the authority to consent to only lifesaving medical treatments.
C) The surrogate decision maker has the authority to authorize admission only to medical facilities and not long-term care facilities.
D) The surrogate decision maker has the authority to have access to all medical records.
E) The surrogate decision maker has the authority to refuse any medical treatment or diagnostic procedure.
Answer: A, B, D, E
Explanation: A) The surrogate decision maker has the authority to consent to any medical treatment or diagnostic procedure.
B) The surrogate decision maker has the authority to consent to only lifesaving medical treatments.
C) The surrogate decision maker has the authority to authorize admission not only to medical facilities but also to long-term care facilities.
D) The surrogate decision maker has the authority to have access to all medical records.
E) The surrogate decision maker has the authority to refuse any medical treatment or diagnostic procedure.
Page Ref: 2841
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.3 Integrate assessment skills in practice. | NLN Competencies: Context and Environment: principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Assessment
Learning Outcome: 49.B. Analyze advance directives as they relate to legal issues. Outline elements of advance directives.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

5) The nurse on the medical unit is admitting a client. When the nurse asks the client about advance directives, the client states, "I have a living will." Which is the purpose of a living will?

A) Provides specific instructions about type of medications the client requires to sustain life

B) Provides specific instructions about what medical treatment the client does not want in the event they can no longer make decisions for themselves

C) Provides specific instructions about who will make healthcare decisions if the client cannot

D) Provides specific instructions about how decisions are to be made if the client is unable to make the decisions

Answer: B

Explanation: A) Living wills do not dictate medication requirements.

B) The living will provides specific instructions about what medical treatment the client chooses to omit or refuse.

C) The durable power of attorney for healthcare identifies who will be making healthcare decisions if the client cannot.

D) Living wills do not dictate how decisions are to be made if the client cannot make them.

Page Ref: 2840

Cognitive Level: Understanding

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Planning

Learning Outcome: 49.B. Analyze advance directives as they relate to legal issues. Describe types of healthcare advance directives.

MNL LO: Analyze the concept of legal issues and its application to nursing care.

6) The nurse working on a medical unit is admitting a client diagnosed with heart failure. During the admission process, the client states, "I do not want to be put on a ventilator because I had to watch my mother die on a ventilator. I want information on making out a living will." When planning care for this client, which intervention is the most appropriate?

A) Educate the client on the process and purpose of a living will and arrange for one to be created should the client choose to do so.

B) Encourage the client to allow for mechanical ventilation.

C) Educate the client on the purpose of mechanical ventilation.

D) Refer the client to a therapist to deal with the death of the client's mother.

Answer: A

Explanation: A) The client asked for information on making out a living will. It would be most appropriate at this time for the nurse to educate the client on the process and purpose of a living will and arrange for one to be created should the client choose to do so.

B) The client already mentioned not wanting mechanical ventilation.

C) The nurse may educate the client on a medical treatment, but that does not address the client's desire for a living will.

D) There is no indication that this client needs therapy.

Page Ref: 2840

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.5 Develop a plan of care. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Planning

Learning Outcome: 49.B. Analyze advance directives as they relate to legal issues. Explain the role of the nurse in assisting families with advance directives.

MNL LO: Analyze the concept of legal issues and its application to nursing care.

Exemplar 49.C Health Insurance Portability and Accountability Act

1) A client on a medical-surgical unit experiences a code blue situation unexpectedly. The emergency situation has ended, and the client survived. The nurses are breaking for lunch and plan to process their feelings about the emergency. Which action by the nurses will facilitate this?
A) Discussing the event outside the hospital
B) Asking management for the use of a private room to debrief
C) Talking while riding in the staff elevator
D) Debriefing about the situation at home
Answer: B
Explanation: A) Discussing the event outside the hospital is inappropriate because anyone could overhear the conversation.
B) To comply with HIPAA, nurses cannot discuss events involving clients in any setting where the conversation can be heard by others, so a private room would be the best place to debrief.
C) The nurses must guard against other health professionals not directly involved with the client overhearing their discussion; consequently, a staff elevator is not acceptable.
D) Discussing the event outside the hospital is inappropriate including discussing client care in the home.
Page Ref: 2844
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.3. Protect confidentiality of protected health information in electronic health records. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination.
Nursing Process: Implementation
Learning Outcome: 49.C.1. Analyze the Health Insurance Portability and Accountability Act (HIPAA) as it relates to legal issues. Explain the purpose of HIPAA.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

2) The nurse is caring for a client on a medical-surgical unit that has just implemented the electronic medical record for client documentation. The client asks the nurse about the facility's computerized system for keeping client information, especially in regard to confidentiality. Which response should the nurse make?
A) "I can see why you're worried, with all the computer hackers out there these days."
B) "Our system was designed with a lot of input from nursing staff."
C) "Electronic medical records are kept in accordance with the HIPAA Privacy Rule."
D) "Don't worry; your information is always safe."
Answer: C
Explanation: A) Reminding the client that there is indeed cause for privacy concerns is not as therapeutic as explaining that the system requires a password.
B) Nurses need to be involved with the design, implementation, and evaluation of electronic medical records to maximize their use and effectiveness, but this does not ensure security.
C) The Privacy Rule protects all "individually identifiable health information" held or transmitted in any form or media, whether electronic, paper, or oral. The rule calls this information protected health information and delineates it further to include information that identifies the individual (e.g., name, address, birth date, and Social Security number) or for which a reasonable basis exists to believe the information can be used to identify the individual.
D) Information in a computer data system may not always be safe, and it would be inappropriate for the nurse to say this.
Page Ref: 2843
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.3. Protect confidentiality of protected health information in electronic health records. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Implementation

Learning Outcome: 49.C. Analyze the Health Insurance Portability and Accountability Act (HIPAA) as it relates to legal issues. Explain how the Privacy Rule covers protected health information.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

3) Which action protects the client's confidentiality?
A) The nurse discusses details of a client's case with family members that will tell no one else.
B) The nurse doesn't reveal outside the healthcare team about being involved with the treatment of a famous client.
C) The nurse thinks HIPAA procedures for the facility are too restrictive to enable necessary sharing of information.
D) The nurse discusses clients only with other employees of the healthcare facility where they work.
Answer: B
Explanation: A) The nurse discussing the details of a client's case with family members is violating client confidentiality.
B) Confidentiality refers to the assurance the client has that private information will not be disclosed without his or her consent. Confidentiality applies both to the nature of the information the nurse obtains from the client and to how the nurse treats client information once it has been disclosed to the nurse. The nurse who does not reveal participating in the treatment of a famous client is protecting that client's confidentiality.
C) The nurse who thinks the facility's HIPAA procedures are too restrictive is neither protecting nor violating confidentiality.
D) The nurse discussing the details of a client's case with any other employees of the facility is violating client confidentiality.
Page Ref: 2844
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.3. Protect confidentiality of protected health information in electronic health records. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Implementation
Learning Outcome: 49.C. Analyze the Health Insurance Portability and Accountability Act (HIPAA) as it relates to legal issues. Differentiate privacy and confidentiality.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

4) The nurse is asked to participate on a committee to ensure that no breaches of client confidentiality occur when providing care. Which actions help ensure client confidentiality when providing care? **Select all that apply.**
A) Withholding private information from other staff unless needed for care
B) Sharing the name and diagnosis of clients upon request
C) Discussing client care with nurses on other units
D) Restricting the discussion of client care to the report room
E) Reviewing the client's care needs with a designated health insurance agent
Answer: A, D, E
Explanation: A) Actions that ensure client confidentiality include only sharing information with staff who are directly involved in care.
B) Client names and diagnoses should only be shared with those who are directly providing care.
C) Actions that ensure client confidentiality include only sharing information with staff who are directly involved in care.
D) Actions that ensure client confidentiality include restricting discussion regarding client care to the report room or other areas that are secure.
E) The nurse is able to review the client's care needs with the designated health insurance agent.
Page Ref: 2844
Cognitive Level: Evaluating
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.3. Protect confidentiality of protected health information in electronic health records. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Implementation
Learning Outcome: 49.C. Analyze the Health Insurance Portability and Accountability Act (HIPAA) as it relates to legal issues. Differentiate privacy and confidentiality.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

5) Which statement explains the purpose for the creation of The Health Insurance Portability and Accountability Act (HIPAA)?

A) Exclude clients with preexisting conditions from healthcare insurance coverage.

B) Designate special rights for individuals who lose other health coverage.

C) Promote medical underwriting in group plans.

D) Relax the rules for disclosure of protected health information.

Answer: B

Explanation: A) The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted by Congress to minimize the exclusion of preexisting conditions as a barrier to healthcare insurance.

B) The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted by Congress to designate special rights for individuals who lose other health coverage.

C) The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted by Congress to eliminate medical underwriting in group plans.

D) The act includes the Privacy Rule, which creates a national standard for the disclosure of private health information. This rule affects all healthcare providers as well as health insurance plan providers, and it defines, not relaxes, the rules for disclosure of protected health information.

Page Ref: 2843

Cognitive Level: Remembering

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: VI.C.3. Protect confidentiality of protected health information in electronic health records. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Implementation

Learning Outcome: 49.C. Analyze the Health Insurance Portability and Accountability Act (HIPAA) as it relates to legal issues. Explain the purpose of HIPAA.

MNL LO: Analyze the concept of legal issues and its application to nursing care.

6) Which information should the nurse understand to be health information not protected under the HIPAA Privacy Rule?
A) A client's Social Security number, birthdate, and mailing address
B) A description of the symptoms of an illness the client has that does not reference the client in any way
C) The details of a client's visit to a medical office including the diagnosis rendered
D) How much the client owes for a treatment rendered to the client
Answer: B
Explanation: A) Social Security number, birthdate, and mailing address are protected health information.
B) A mere description of the symptoms for an illness that does not reference the client in any way is not protected health information.
C) Protected health information includes the details of a client's visit to a medical office including the diagnosis.
D) Protected health information includes the amount of money a client owes for receiving a treatment.
Page Ref: 2843
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: VI.C.3. Protect confidentiality of protected health information in electronic health records. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Principles of informed consent, confidentiality, patient self-determination. | Nursing Process: Implementation
Learning Outcome: 49.C. Analyze the Health Insurance Portability and Accountability Act (HIPAA) as it relates to legal issues. Explain how the Privacy Rule covers protected health information.

MNL LO: Analyze the concept of legal issues and its application to nursing care.

Exemplar 49.D Mandatory Reporting

1) While making rounds on the night shift, a nursing supervisor notes that a 73-year-old client under observation following a myocardial infarction has multiple visible bruises on the arms and legs. The supervisor suspects abuse because nothing in the client's chart suggests this client should have sustained these injuries. This state's good faith immunity applies in cases of suspected abuse not only of children but also of older adults or adults with disabilities. Which action has the highest priority for the nursing supervisor in this situation?
A) Notify authorities regarding the suspected abuse.
B) Do nothing about the situation.
C) Notify the security department.
D) Ask a shift nurse about the source of the injuries.
Answer: A
Explanation: A) States also have specific laws pertaining to the mistreatment of adults and older adults. These laws may be similar to those that govern the abuse and neglect of children.
B) Doing nothing is not an option. The client has obvious injures that indicate abuse.
C) Security is not the appropriate department to notify unless the injuries were sustained at work.
D) Questioning a shift nurse about the source of the injuries is fine to do but should not replace reporting the injuries to the appropriate authorities, which should be done in this case because the supervisor suspects abuse.
Page Ref: 2846
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Act in accordance with legal and regulatory requirements, including HIPAA, for faculty, students, patients, and families. | Nursing Process: Implementation
Learning Outcome: 49.D. Analyze mandatory reporting as it relates to legal issues. Differentiate considerations related to mandatory reporting across the lifespan.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

2) During an assessment of a child in the urgent care clinic, the nurse notes that the child has a swollen and split lip. When asking the parent how the child's lip injury occurred, the parent responds, "We are here for my child's ear not my child's lip." For which reason should this incident be reported?
A) The child reports that a parent caused the injury.
B) The lip injury is unrelated to the ear infection.
C) The nurse can be sued if there is no abuse.
D) Suspected abuse must be reported.
Answer: D
Explanation: A) Most children will not accuse an abuser; rather, they generally protect the abuser.
B) The lip injury being unrelated to the ear infection is not a reason not to report the injury.
C) The reason for the law is that experts can assess the situation and determine if abuse has occurred. The nurse is protected by good faith immunity.
D) Suspected child abuse must be reported by law. Healthcare personnel are protected by good faith immunity because the ultimate goal is the protection of the child.
Page Ref: 2846
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Act in accordance with legal and regulatory requirements, including HIPAA, for faculty, students, patients, and families. | Nursing Process: Implementation

Learning Outcome: 49.D. Analyze mandatory reporting as it relates to legal issues. Differentiate considerations related to mandatory reporting across the lifespan.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

3) An adolescent client with a sexually transmitted infection (STI) says to the nurse, "Promise you won't tell my parents about my condition." The agency policy is that all STIs must be reported in accordance with federal and state law. Which action by the nurse is appropriate?
A) Disclosing information to the parents
B) Reporting the STI to the proper authorities
C) Respecting the client's privacy and confidentiality by not mentioning or reporting the STI
D) Telling other nurses in the clinic that the client has an STI
Answer: B
Explanation: A) Because of confidentiality issues, the nurse should not report the STI to the parents.
B) In this case, the nurse is required to report information about the client's STI to the state health department.
C) Not reporting the infection is not an option. The infection must be reported.
D) Because of confidentiality issues, the nurse should not report the STI to other nurses not involved in the client's care.
Page Ref: 2847
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Act in accordance with legal and regulatory requirements, including HIPAA, for faculty, students, patients, and families. | Nursing Process: Implementation
Learning Outcome: 49.D. Analyze mandatory reporting as it relates to legal issues. Outline situations that require mandatory reporting.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

4) The nurse is in the midst of a complicated client care situation and is not sure what needs to be done with some information. Which healthcare issues must the nurse report to the state? **Select all that apply.**
A) Amputation of a limb
B) Death of a client
C) Death of a neonate
D) Diagnosis of tuberculosis
E) Kidney transplant
Answer: B, C, D
Explanation: A) Limb amputations do not need to comply with mandatory reportable events.
B) The term mandatory reporting refers to a legal requirement to report an act, event, or situation that is designated by state or local law as a reportable event. All states mandate the reporting of certain vital statistics, including deaths.
C) Many states require healthcare providers to report neonatal deaths.
D) Federal and state laws mandate the reporting of communicable diseases such as tuberculosis.
E) Transplants do not need to comply with mandatory reportable events.
Page Ref: 2850
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Act in accordance with legal and regulatory requirements, including HIPAA, for faculty, students, patients, and families. | Nursing Process: Implementation

Learning Outcome: 49.D. Analyze mandatory reporting as it relates to legal issues. Describe the legalities of mandatory reporting.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

5) The nurse who reports suspected child abuse, honestly believing it to have occurred, is not subject to civil or criminal liabilities when the subsequent investigation does not make a determination of abuse. In which way should this situation be categorized?
A) Good faith immunity
B) Protection of privacy
C) Breach of confidentiality
D) Criminal malfeasance
Answer: A
Explanation: A) In every state, healthcare workers are protected from civil or criminal liabilities when they report suspected child abuse in good faith, even if the subsequent investigation does not make a determination of abuse. This is called good faith immunity.
B) This situation is not protection of privacy.
C) This situation is not breach of confidentiality.
D) This situation is not criminal malfeasance.
Page Ref: 2846
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Act in accordance with legal and regulatory requirements, including HIPAA, for faculty, students, patients, and families. | Nursing Process: Implementation
Learning Outcome: 49.D. Analyze mandatory reporting as it relates to legal issues. Describe the legalities of mandatory reporting.

MNL LO: Analyze the concept of legal issues and its application to nursing care.

6) Which statement describes the nurse's duty to investigate suspected abuse of a pediatric client before reporting it?
A) The nurse must question a parent or guardian about the suspected abuse.
B) The nurse must personally observe the client being abused.
C) The nurse must identify at least two witnesses who will testify that the client was abused.
D) The nurse does not need to investigate suspected abuse of a pediatric client.
Answer: D
Explanation: A) The nurse is not required to question a parent or guardian about the abuse.
B) The nurse is not required to personally observe the client being abused.
C) The nurse is not required to identify witnesses who will testify to the abuse.
D) Regardless of the situation, the nurse is not required to conduct any type of investigation or otherwise confirm that the suspected abuse of a pediatric client has, in fact, occurred. The nurse is required only to have a good faith suspicion based on information disclosed by a client, physical symptoms observed in a client, or the nurse's personal observations of behavior on the part of a client, colleague, or third party.
Page Ref: 2846
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: I.A.7. Explore ethical and legal implications of patient-centered care. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Context and Environment: Act in accordance with legal and regulatory requirements, including HIPAA, for faculty, students, patients, and families. | Nursing Process: Implementation
Learning Outcome: 49.D. Analyze mandatory reporting as it relates to legal issues. Describe the legalities of mandatory reporting.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

Exemplar 49.E Risk Management

1) The nurse educator is planning a class for a group of nursing students regarding risk management. Which information should the educator include in this presentation? **Select all that apply.**
A) Risk management seeks to prevent harm.
B) Risk management empowers clients.
C) Risk management controls the cost of supplies.
D) Risk management examines past mistakes and identifies potential hazards.
E) Risk management ensures that nurses are truthful.
Answer: A, D
Explanation: A) The major goal of a risk management department is to limit a healthcare agency's financial and legal risk associated with the delivery of care, particularly in terms of lawsuits, ideally before incidents occur. This involves preventing harm to clients.
B) Empowerment of clients is not a goal of risk management.
C) Controlling the cost of supplies is not a goal of risk management.
D) The major goal of a risk management department is to limit a healthcare agency's financial and legal risk associated with the delivery of care, particularly in terms of lawsuits, ideally before incidents occur. This involves examining past mistakes and identifying potential hazards.
E) Truthfulness of nurses is not a goal of risk management.
Page Ref: 2848
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 5.1 Apply quality improvement principles in care delivery. | NLN Competencies: Quality and Safety: Communicate potential risk factors and actual errors. | Nursing Process: Planning
Learning Outcome: 49.E. Analyze risk management as it relates to legal issues. Explain the concept of risk management.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

2) A novice nurse attends a lecture regarding risk management. Which action should the nurse implement to reduce risks in practice?
A) Not discussing errors made
B) Questioning every order that the physician writes
C) Urging the nurse's organization to purchase liability insurance
D) Storing unused equipment in the halls of the unit
Answer: C
Explanation: A) Risk management entails analyzing errors to determine causes and changing policy to reduce more errors.
B) The nurse does not need to question every order that a physician writes; the nurse is responsible only for questioning orders that may injure clients.
C) Healthcare organizations can use several strategies to minimize risk. One of the most basic strategies is protecting against financial risk by purchasing insurance or by self-insuring.
D) Storing unused equipment in the hall serves to eliminate risk of contamination but could increase the risk due to injury.
Page Ref: 2848
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 5.1 Apply quality improvement principles in care delivery. | NLN Competencies: Quality and Safety: Communicate potential risk factors and actual errors. | Nursing Process: Implementation
Learning Outcome: 49.E. Analyze risk management as it relates to legal issues. Outline strategies for risk management.

MNL LO: Analyze the concept of legal issues and its application to nursing care.

3) The nurse is concerned about the risk involved when implementing healthcare provider prescriptions for a newly admitted client. Which orders should the nurse question to reduce this risk? **Select all that apply.**

A) Written for a postoperative client
B) One that a client questions
C) One that is written when client's condition changes
D) Any verbal order
E) One that is incomplete

Answer: B, C, E

Explanation: A) Orders written for postoperative clients do not all need to be questioned.
B) Nurses should question any order a client questions.
C) Nurses should question any order if the client's condition has changed.
D) Verbal orders should be recorded accurately to avoid miscommunication, but they do not all need to be questioned.
E) It is the nurse's responsibility to seek clarification of ambiguous or seemingly erroneous orders from the prescribing physician.

Page Ref: 2848-2849

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Communicate potential risk factors and actual errors. | Nursing Process: Implementation

Learning Outcome: 49.E. Analyze risk management as it relates to legal issues. Outline strategies for risk management.

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MNL LO: Analyze the concept of legal issues and its application to nursing care.

4) The nursing instructor is evaluating the success of training provided to staff nurses on ways to reduce the incidence of pediatric medication errors. Which observations indicate that training provided to the staff has been effective? **Select all that apply.**

A) Double-checking medication calculations.
B) Refusing to dilute medications.
C) Using liquid preparations.
D) Asking the pharmacy to prepare the exact doses.
E) Asking each other to validate placement of decimal points.

Answer: A, C, E

Explanation: A) Children are at a higher risk for medical error than other clients and also may be more vulnerable to harm from errors due to their immature physiology. Reasons for increased medical error among children include miscalculation of doses and amounts and incorrect placement of the decimal point in calculations. Nurses who double-check medication calculations are demonstrating that the training was effective.

B) The nurses should not be refusing to dilute medications because many preparations require dilution to achieve the small dosages required by infants.

C) Nurses who use liquid preparations are demonstrating that the training was effective.

D) Nurses should not expect the pharmacy to prepare the medications in exact doses.

E) Nurses who ask another nurse to validate the placement of the decimal point are demonstrating that the training was effective.

Page Ref: 2849

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Communicate potential risk factors and actual errors. | Nursing Process: Evaluation

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Learning Outcome: 49.E. Analyze risk management as it relates to legal issues. Outline strategies for risk management.

MNL LO: Analyze the concept of legal issues and its application to nursing care.

5) A medication error occurred, and the nurse is preparing to complete an incident report. Which information is required to thoroughly complete this report? **Select all that apply.**
A) Name of client involved in the incident
B) Location where incident report is completed
C) Date and time of the incident
D) Medication involved in the incident
E) Number of hours the nurse was at work before the incident occurred
Answer: A, C, D
Explanation: A) An incident report is an agency record of an accident or incident occurring within the agency. Incident reports generally include the names and identifying information of any clients and healthcare personnel involved in the incident.
B) The location of the incident, not where the incident report itself is completed, should be entered.
C) Incident reports include the time and date of the incident.
D) If a medication is involved, the incident report should include the medication's name and dosage.
E) The number of hours the nurse worked before the incident occurred is not a part of the report.
Page Ref: 2849
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: V.A.5. Describe factors that create a culture of safety (such as, open communication strategies and organizational error reporting systems). | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Communicate potential risk factors and actual errors. | Nursing Process: Implementation
Learning Outcome: 49.E. Analyze risk management as it relates to legal issues. Explain the use of incident reports.
MNL LO: Analyze the concept of legal issues and its application to nursing care.

Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e (Pearson)
Module 50 Quality Improvement

The Concept of Quality Improvement

1) The nurse is participating in a quality improvement process related to improving care for clients at risk for skin breakdown. Which best describes the purpose of this process?
A) Improve client outcomes
B) Advance the nurse's career
C) Fulfill legal requirements
D) Maintain accreditation
Answer: A
Explanation: A) Quality improvement is the name for the processes used by an agency to measure and improve aspects of client care, including overall outcomes.
B) Participation may help the nurse advance in their career, but that is usually accomplished by returning to school for a higher degree.
C) Nurses are encouraged to participate in quality improvement programs but are not legally required to do so.
D) Although maintaining accreditation is important, it is not the primary reason for engaging in quality improvement processes.
Page Ref: 2853
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV.A.1. Describe strategies for learning about the outcomes of care in the setting in which one is engaged in clinical practice. | AACN Domains and Competencies: 5.1 Apply quality improvement principles in care delivery. | NLN Competencies: Quality & Safety: Contribute to assessment of outcome achievement. | Nursing Process: Implementation
Learning Outcome: 50.4. Outline the quality improvement process.
MNL LO: Analyze the concept of quality improvement and its application to nursing care.

2) The quality assurance officer notes that one particular nursing unit has received a higher-than-usual number of negative client responses about aspects of the nursing care during the previous quarter. Based on this data, to which benchmarking issue should the quality assurance officer pay particular attention during the review process?
A) Structure
B) Process
C) Outcome
D) Competency
Answer: B
Explanation: A) Structure evaluation focuses on organizational structure and resources.
B) Process standards focus on the steps used to lead to a particular outcome, including whether a set of steps exists and whether those steps are being followed.
C) Outcome evaluation focuses on the performance of a process, such as the number of bedridden clients who develop a pressure injury.
D) Competency is not one of the components of quality assurance evaluation.
Page Ref: 2855
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV.B.5. Use quality measures to understand performance. | AACN Domains and Competencies: 5.1 Apply quality improvement principles in care delivery. | NLN Competencies: Quality & Safety: Contribute to assessment of outcome achievement. | Nursing Process: Planning
Learning Outcome: 50.4. Outline the quality improvement process.
MNL LO: Analyze the concept of quality improvement and its application to nursing care.

3) The nurse is working in a healthcare setting that has implemented Lean Six Sigma. Which action should the nurse anticipate with regard to this model?
A) Shorter breaks
B) Ordering extra supplies
C) Replacing licensed with unlicensed personnel
D) Decreasing staff when the census is low
Answer: D
Explanation: A) A shortened break time would not be considered reducing waste.
B) The unit would cut back on ordering supplies that are not needed when following this model.
C) Replacing licensed staff members with unlicensed personnel may not be safe.
D) Lean Six Sigma focuses on eliminating waste and improving process flow. Thus, when a unit's census decreases, the unit's manager would decrease the number of staff.
Page Ref: 2861
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV.A.5. Describe approaches for changing processes of care. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Policies and procedures. | Nursing Process: Implementation
Learning Outcome: 50.5. Differentiate common quality management programs.
MNL LO: Analyze the concept of quality improvement and its application to nursing care.

4) The nurse is asked to participate in a record review to verify accuracy and proper use of certain interdisciplinary resources. In which process will the nurse be participating?
A) Peer review
B) Interprofessional audit
C) Utilization review
D) Benchmarking
Answer: B
Explanation: A) A peer review is a professional critique of a colleague's work on the basis of predetermined standards.
B) An audit is an examination of records to verify accuracy and proper use. Because this audit is focused on resources used by multiple professionals, it would be classified as an interprofessional audit.
C) A utilization review analyzes the use of resources to identify areas of overuse, misuse, and underuse.
D) Benchmarking is a method that is used to compare the performance of an individual or organization to industry standards.
Page Ref: 2853
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV. B.7. Identify gaps between local and best practice. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Contribute to assessment of outcome achievement. | Nursing Process: Planning
Learning Outcome: 50.4. Outline the quality improvement process.

MNL LO: Analyze the concept of quality improvement and its application to nursing care.

5) Which statements best describe how a quality improvement process can contain healthcare costs? **Select all that apply.**
A) "Promoting safety increases the cost of care."
B) "Medication errors decrease the cost of care."
C) "High nurse-to-client ratios result in decreased readmission rates."
D) "Increased nursing staff has been linked to decreased infection rates."
E) "Use of computers increases the number of lawsuits."
Answer: C, D
Explanation: A) Promoting safety is a cost-containment measure because it decreases injury to the client and the consequent risk of lawsuits.
B) Medication errors increase cost due to harm to the client and increased length of stay.
C) Studies have shown that increasing the nurse-to-client ratio can decrease overall cost because readmission rates are reduced with RN care.
D) Studies have shown that increasing the nurse-to-client ratio can decrease overall infection rates.
E) Computers increase efficiency and reduce cost as a result. Lawsuits do not increase because of computer use; they increase when computers are used improperly.
Page Ref: 2852
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV.C.2. Value own and others' contributions to outcomes of care in local care settings. | AACN Domains and Competencies: 7.2 Incorporate consideration of cost-effectiveness of care. | NLN Competencies: Quality & Safety: Current best practices. | Nursing Process: Implementation
Learning Outcome: 50.4. Outline the quality improvement process.
MNL LO: Analyze the concept of quality improvement and its application to nursing care.

6) Which outcome is desired when readmission rates are decreased?
A) An increased use of overtime
B) A decrease in client satisfaction
C) An increase in client care supplies
D) A decreased cost of care
Answer: D
Explanation: A) Overtime is not necessarily reduced by an increase in staff, depending on the number of nurses available at any given time.
B) Studies show that client satisfaction increases with an increase in RN staff.
C) Decreasing readmission rates will likely decrease the use of client care supplies, not increase it.
D) Research has shown that an increase in RN staff decreases a unit's readmission rate. Because readmission is reduced, cost of care is also reduced.
Page Ref: 2852
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV.C.2. Value own and others' contributions to outcomes of care in local care settings. | AACN Domains and Competencies: 7.2 Incorporate consideration of cost-effectiveness of care. | NLN Competencies: Quality & Safety: Current best practices. | Nursing Process: Planning
Learning Outcome: 50.4. Outline the quality improvement process.
MNL LO: Analyze the concept of quality improvement and its application to nursing care.

7) The nurse working in a blame-free environment provides medication to a client at the wrong time. No harm came to the client as a result of the nurse's error, and the nurse files a report about the medication error. Which action by the risk management team should the nurse anticipate?
A) Taking disciplinary action
B) Reporting to the board of nursing
C) Monitoring all nurses on the unit
D) Suggesting system changes to prevent future errors
Answer: D
Explanation: A) The risk management team would not be responsible for implementing any disciplinary actions.
B) The situation does not warrant reporting the nurse to the board of nursing.
C) It is not prudent for the risk management team to monitor all nurses who administer medications on the unit.
D) When a nurse makes an error and reports it, the risk management team will investigate to discover causes for the error and effect policy changes that can prevent future errors, improving the level of client care.
Page Ref: 2858-2859
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV.A.5. Describe approaches for changing processes of care. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Communicate potential risk factors and actual errors. | Nursing Process: Implementation
Learning Outcome: 50.4. Outline the quality improvement process.
MNL LO: Analyze the concept of quality improvement and its application to nursing care.

8) While preparing a client for surgery, the nurse marks the arm that is to be amputated and participates in a "time out" procedure before the surgery begins. Which sentinel event is this action intended to prevent?
A) Ineffective control of the client's pain
B) The lack of healing of the stump
C) The client being mildly oversedated
D) The removal of the wrong arm
Answer: D
Explanation: A) Pain control is individual and is not a sentinel event.
B) The inability to heal properly is an expected event in some clients, such as clients with diabetes.
C) Mild oversedation is not a sentinel event, as the client is most likely on a ventilator during surgery.
D) A sentinel event is an unexpected event that causes death or severe physical or psychological injury. The removal of the client's incorrect arm would be a sentinel event.
Page Ref: 2856
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Current best practices. | Nursing Process: Implementation
Learning Outcome: 50.4. Outline the quality improvement process.
MNL LO: Analyze the concept of quality improvement and its application to nursing care.

9) In which order should the steps of the quality improvement process be reviewed to determine whether it was completed correctly?

A) Research factors that contribute to better outcomes.
B) Compare outcomes to benchmarks.
C) Identify areas for improvement.
D) Analyze current protocols of care and associated outcomes.
E) Implement changes to improve outcomes.
F) Analyze client outcomes to determine effectiveness of changes.

Answer: D, B, C, A, E, F

Explanation: Quality improvement involves analyzing current protocols of care and their associated outcomes, comparing those outcomes to leaders in high-quality care through benchmarking, identifying areas for improvement, researching factors that contribute to better outcomes, and implementing changes to improve outcomes. Client outcomes must then be analyzed to determine the effectiveness of the changes and identify areas for further improvement.

Page Ref: 2853

Cognitive Level: Understanding

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: IV.A.1. Describe strategies for learning about the outcomes of care in the setting in which one is engaged in clinical practice. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Contribute to assessment of outcome achievement. | Nursing Process: Evaluation

Learning Outcome: 50.4. Outline the quality improvement process.

MNL LO: Analyze the concept of quality improvement and its application to nursing care.

10) The nurse is participating in an intraprofessional assessment as part of a quality improvement process. Which activities should the nurse anticipate will be included in this assessment? **Select all that apply.**

A) Utilization reviews
B) Peer review
C) Audits
D) Performance appraisals
E) Outcomes management

Answer: B, C, E

Explanation: A) Utilization reviews are completed when conducting an interprofessional assessment.

B) Intraprofessional assessment occurs within a group of individuals with a similar position in the healthcare system, such as a group of nurses. An intraprofessional assessment is important for identifying areas of improvement at each level of care and includes peer review.

C) An intraprofessional assessment is important for identifying areas of improvement at each level of care and includes audits.

D) Performance appraisals are not a part of either intra- or interdisciplinary assessments.

E) An intraprofessional assessment is important for identifying areas of improvement at each level of care and includes outcomes management.

Page Ref: 2853-2854

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Management of Care

Standards: QSEN Competencies: II.C.2. Appreciate importance of intra- and interprofessional collaboration. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Contribute to assessment of outcome achievement. | Nursing Process: Planning

Learning Outcome: 50.4. Outline the quality improvement process.

MNL LO: Analyze the concept of quality improvement and its application to nursing care.

11) Which situations would be considered a sentinel event? **Select all that apply.**
A) Delivery of radiation to the wrong body region
B) Invasive surgical procedure at the wrong site
C) Homicide of a staff member while at the facility
D) Homicide of a client while at the facility
E) Administration of a compatible blood transfusion
Answer: A, B, C, D
Explanation: A) Delivery of radiation to the wrong body region is a sentinel event.
B) Invasive surgery at the wrong site is a sentinel event.
C) Homicide of a staff member while at the facility is a sentinel event.
D) Homicide of a client while at the facility is a sentinel event.
E) Administration of a compatible blood transfusion would be desired. Administration of an incompatible blood transfusion would be a sentinel event.
Page Ref: 2856
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV.B.7. Identify gaps between local and best practice. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Sentinel events and root cause analysis; System effectiveness. | Nursing Process: Planning
Learning Outcome: 50.4. Outline the quality improvement process.
MNL LO: Analyze the concept of quality improvement and its application to nursing care.

12) The nurse is administering medications to a client. Which action is most likely to lead to an adverse event?
A) The nurse verifies tube placement prior to administering the medications.
B) The nurse checks for known allergies prior to administering the medications.
C) The nurse combines medications with the same active ingredient.
D) The nurse has a second nurse check the medication order.
Answer: C
Explanation: A) Verifying tube placement prior to administering medications is appropriate and would help reduce medication errors.
B) Checking for known allergies prior to administering medications would help reduce a medication error.
C) It is not appropriate to combine medications with the same active ingredient, as this is likely to increase medication errors.
D) Having a second nurse check the medication order is an appropriate action and would help reduce medication errors.
Page Ref: 2857
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: IV.C.1. Appreciate that continuous quality improvement is an essential part of the daily work of all health professionals. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Communicate potential risk factors and actual errors. | Nursing Process: Implementation
Learning Outcome: 50.4. Outline the quality improvement process.
MNL LO: Analyze the concept of quality improvement and its application to nursing care.

13) Which statement regarding standards of care in the hospital setting is inaccurate?
A) "Standards of care are based on models of high-quality performance."
B) "Process standards focus on the steps used to lead to a particular outcome."
C) "Process standards focus on human resources and general organizational structure."
D) "Outcome standards focus on the performance of a process."
Answer: C
Explanation: A) Standards of care are based on models of high-quality performance.
B) Process standards focus on the steps used to lead to a particular outcome.
C) "Process standards focus on human resources and general organizational structure" is incorrect.
D) Outcome standards focus on the performance of a process.
Page Ref: 2855
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV.B.5. Use quality measures to understand performance. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Contribute to assessment of outcome achievement. | Nursing Process: Evaluation
Learning Outcome: 50.4. Outline the quality improvement process.
MNL LO: Analyze the concept of quality improvement and its application to nursing care.

14) Which statement correctly describes quality management?
A) Quality management compares nursing processes to accepted standards to prevent errors in treatment.
B) Quality management refers to systematic actions that lead to improvements in healthcare services.
C) Quality management is the degree to which health services increase the likelihood of desired health outcomes.
D) Quality management provides clients with appropriate service in a technically competent manner.
Answer: A
Explanation: A) Quality management includes evaluation of medical and nursing processes for quality and effectiveness compared to accepted standards in order to correct problems before they harm clients and to prevent errors in treatment.
B) Quality improvement refers to systematic actions that lead to improvements in healthcare services.
C) Quality is the degree to which health services increase the likelihood of desired health outcomes. High-quality care provides clients with appropriate service in a technically competent manner.
D) High-quality care provides clients with appropriate service in a technically competent manner.
Page Ref: 2860
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV.B.5. Use quality measures to understand performance. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Contribute to assessment of outcome achievement. | Nursing Process: Implementation
Learning Outcome: 50.1. Summarize the need for improving the quality of healthcare.
MNL LO: Analyze the concept of quality improvement and its application to nursing care.

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15) Which federal initiative contains the three broad aims of better care, healthy people/healthy communities, and affordable care?
A) National Database of Nursing Quality Indicators
B) *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*
C) National Patient Safety Goals
D) National Quality Strategy
Answer: D

Explanation: A) The National Database of Nursing Quality Indicators (NDNQI) aims to collect and provide data that identify areas for improvement and encourage facilities to meet quality goals.
B) *Patient Safety and Quality: An Evidence-Based Handbook for Nurses* aims to collect and provide data that identify areas for improvement and encourage facilities to meet quality goals.
C) National Patient Safety Goals by the Joint Commission aims to collect and provide data that identify areas for improvement and encourage facilities to meet quality goals.
D) To improve the health of the population, the USDHHS has developed the National Quality Strategy, which contains three broad aims: better care, healthy people/healthy communities, and affordable care.

Page Ref: 2852
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV.B.5. Use quality measures to understand performance. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Current best practices. | Nursing Process: Implementation
Learning Outcome: 50.2. Summarize federal, state, and local initiatives to improve healthcare.
MNL LO: Analyze the concept of quality improvement and its application to nursing care.

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16) Which major nursing concept has the strongest relationship to the identification of areas for quality improvement, such as tracking data on healthcare-associated infections?
A) Ethics
B) Safety
C) Informatics
D) Evidence-based practice
Answer: C
Explanation: A) Ethics can contribute to quality improvement, but not by easily tracking poor client outcomes.
B) Safety can contribute to quality improvement, but not by easily tracking poor client outcomes.
C) Informatics can be used to identify areas for improvement, such as tracking healthcare-associated infections. Without informatics, tracking adverse outcomes would be time-consuming and potentially cost-prohibitive. With the advent of technology and informatics, statistics and client outcomes are easier to track, making quality improvement more efficient.
D) Evidence-based practice can contribute to quality improvement, but not by easily tracking poor client outcomes.
Page Ref: 2854
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: QSEN Competencies: IV.B.1. Seek information about outcomes of care for populations served in care setting. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Use technologies that contribute to safety. | Nursing Process: Evaluation
Learning Outcome: 50.3. Outline the relationship between quality improvement and other concepts.
MNL LO: Analyze the concept of quality improvement and its application to nursing care.

***Nursing: A Concept-Based Approach to Learning Vol. 1 & 2, 4e* (Pearson)**

Module 51 Safety

The Concept of Safety

1) A client asks the nurse if the staff members make many mistakes because there are so many posters and signs about safety on the walls. Which response by the nurse is best?
A) "The nurses here are safe. The posters are directed at certain members of the healthcare team who have been making more mistakes than usual."
B) "You don't need to worry about posters on the wall. Our primary concern is getting you well."
C) "We never make mistakes here. We want the public to know that we have client safety goals here."
D) "There is a potential for errors in all healthcare settings. The posters remind the staff and the clients of the need to work together to prevent them."
Answer: D
Explanation: A) The posters are not directed at certain members of the healthcare team.
B) Clients should be concerned about safety.
C) Mistakes can occur in all healthcare settings; behaviors, not goals, help to prevent them.
D) Client safety initiatives address collaborative efforts by staff and clients to promote safety in healthcare settings. These initiatives require collaboration by all members of the team, including clients.
Page Ref: 2864
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.8. Use national patient safety resources for own professional development and to focus attention on safety in care settings. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Tools for effective and open communication. | Nursing Process: Implementation
Learning Outcome: 51.7. Summarize collaborative efforts used by interprofessional teams and patients for safety in healthcare settings.
MNL LO: Analyze the concept of safety and its application to nursing care.

2) Several nurses are discussing the Joint Commission's National Patient Safety Goals during a staff meeting. Which element of performance should the nurses implement to meet the goal of identifying clients correctly?
A) Labeling all medications with the client's name
B) Consistently using two methods to identify the client
C) Asking the client's name before conducting assessments
D) Marking the intended surgical site on the client
Answer: B
Explanation: A) Labeling medications with the medication information helps prevent medication errors.
B) Two elements of performance that accompany the goal to identify clients correctly include consistently using two methods to identify the client.
C) Asking the client's name before conducting assessments is not associated with a National Patient Safety Goal.
D) Marking the intended surgical site on the client helps prevent surgical errors.
Page Ref: 2871
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Policies and procedures. | Nursing Process: Implementation
Learning Outcome: 51.7. Summarize collaborative efforts used by interprofessional teams and patients for safety in healthcare settings.
MNL LO: Analyze the concept of safety and its application to nursing care.

3) After completing an assessment, the nurse determines a client is at risk for safety issues. Which data supports the nurse's conclusion?
A) Lives with adult married daughter and family
B) Occasional dizziness with walking
C) Follows a vegetarian diet
D) Receives an annual ophthalmologic examination
Answer: B
Explanation: A) Living with family does not increase the client's risk for safety issues.
B) Risks to safety include factors that can impact falls such as mobility issues or balance.
C) Eating a vegetarian diet does not increase the client's risk for safety issues.
D) Having annual eye examinations does not increase the client's risk for safety issues.
Page Ref: 2868
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Communicate potential risk factors and actual errors. | Nursing Process: Assessment
Learning Outcome: 51.5. Differentiate common assessment data used to examine safety.
MNL LO: Analyze the concept of safety and its application to nursing care.

4) Which practices support promotion of health safety? **Select all that apply.**
A) Exercise every day
B) Avoid driving when sleepy or tired
C) Eliminate all foods containing fat
D) Wear seat belts
E) Only see healthcare providers when sick
Answer: A, B, D
Explanation: A) Health promotion involves many different practices, including staying physically active.
B) Health promotion involves many different practices, including following guidelines for motor vehicle safety.
C) Eliminating all foods containing fat would eliminate necessary nutrients from the diet.
D) Health promotion involves many different practices, including following guidelines for motor vehicle safety.
E) Clients should see a healthcare provider at least annually for a checkup even if not sick.
Page Ref: 2866
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Quality and Safety: Current best practices. | Nursing Process: Implementation
Learning Outcome: 51.4. Explain the promotion of health safety.
MNL LO: Analyze the concept of safety and its application to nursing care.

5) A hospital has created a culture of safety by providing organizational support for safety initiatives and by training and encouraging healthcare employees in the area of safety. Which other step is needed to promote safety for everyone in the healthcare environment?
A) Keep a mindset for quality of safe practice
B) Post signs related to safety on the walls
C) Engage clients in their own safety
D) Be a safety advocate for others
Answer: C
Explanation: A) Keeping a mindset for quality of safe practice relates to the organizational support for safety.
B) Posting signs related to safety relates to the organizational support for safety.
C) Healthcare facilities should use a three-pronged approach to quality and safety for everyone, including organizational support for keeping safety a priority, encouraging employees to consistently choose to follow health safety rules and standards, and actively engaging clients in every aspect of their care, including safety.
D) Being a safety advocate for others is related to employees maintaining safety standards.
Page Ref: 2864
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.A.5. Describe factors that create a culture of safety (such as, open communication strategies and organizational error reporting systems). | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Encourage patients and families to communicate their observations and concerns regarding safety. | Nursing Process: Implementation
Learning Outcome: 51.2. Differentiate common alterations of safety.
MNL LO: Analyze the concept of safety and its application to nursing care.

6) When a nurse performs or observes nursing practices that are not safe, the nurse has a responsibility to report those actions. This principle ties the concept of safety to which other nursing concept?
A) Accountability
B) Advocacy
C) Assessment
D) Clinical decision making
Answer: A
Explanation: A) Nurses are accountable for their actions, so all unsafe nursing practices should be reported and addressed.
B) This principle does not reflect advocacy.
C) This principle does not reflect assessment.
D) This principle does not reflect clinical decision making.
Page Ref: 2867
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.4. Communicate observations or concerns related to hazards and errors to patients, families, and the healthcare team. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Communicate potential risk factors and actual errors. | Nursing Process: Implementation
Learning Outcome: 51.3. Summarize the relationship between safety and other concepts.
MNL LO: Analyze the concept of safety and its application to nursing care.

7) The nurse is caring for a client with a self-reported latex allergy. Which strategy can the nurse use to ensure the safety of this client?
A) Wear hypoallergenic gloves
B) Wear gloves with powder
C) Wash hands after taking gloves off
D) Keep beta adrenergic agonists on hand
Answer: C
Explanation: A) Not all hypoallergenic gloves are latex-free.
B) Powder from the gloves can absorb the latex and be transferred to clients through touch or through the air.
C) Powder from the gloves can absorb the latex and be transferred to clients through touch or through the air. Therefore, it is important to wash hands after removing gloves, especially gloves with powder.
D) Beta adrenergic agonists are used for the treatment of asthma, which may develop with chronic latex exposure in a sensitive individual, but it will not affect the early symptoms of latex allergy.
Page Ref: 2868
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Current best practices. | Nursing Process: Implementation
Learning Outcome: 51.6. Explain independent interventions that can be implemented for the patient's safety.
MNL LO: Analyze the concept of safety and its application to nursing care.

Exemplar 51.A Health Promotion and Injury Prevention across the Lifespan

1) The nurse is conducting a class for a group of pregnant clients. Which topic should the nurse include when teaching this group about safety of the fetus?
A) Pedestrian accidents
B) Suffocation in the crib
C) Alcohol consumption
D) Drowning
Answer: C
Explanation: A) Pedestrian accidents are seen in the older adult.
B) Suffocation in the crib is a safety hazard for both newborns and infants.
C) Alcohol consumption is a safety hazard for the fetus, and pregnant women should be educated about the importance of not drinking alcoholic beverages while pregnant.
D) Drowning is seen in toddlers and preschoolers.
Page Ref: 2872
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Communicate potential risk factors and actual errors. | Nursing Process: Implementation
Learning Outcome: 51.A.1. Analyze health promotion and injury prevention across the lifespan as they relate to safety. Summarize the risks for injury, health promotion, and injury prevention in the perinatal period and for newborns and infants.
MNL LO: Analyze the concept of safety and its application to nursing care.

2) The nurse conducted a class on fall prevention for a group of older adult clients in the community. Which observation during a client home visit indicates that teaching on fall prevention was effective?
A) All meat is placed in the freezer.
B) The locks were changed on the doors.
C) Scatter rugs are placed in the kitchen.
D) A shower seat was placed in the shower.
Answer: D
Explanation: A) Placing meat in the freezer does not help prevent falls.
B) Changing the locks may promote safety if there have been frequent break-ins, but there is no evidence of that.
C) Scatter rugs in any area of the home are a safety hazard.
D) A shower seat in the shower can prevent falls. The client who installed the seat has understood the nurse's teaching.
Page Ref: 2878-2879
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 51.A. Analyze health promotion and injury prevention across the lifespan as they relate to safety. Outline the risks for injury, health promotion, and injury prevention for older adults.
MNL LO: Analyze the concept of safety and its application to nursing care.

3) The nurse is conducting a home risk assessment for a family with toddler and preschool-age children. Which should the nurse identify as the priority safety hazard?

A) Safety plugs in electrical outlets
B) Medications on the kitchen counter
C) Lack of helmets next to bicycles
D) Child locks on the doors

Answer: B

Explanation: A) Safety plugs are appropriate for this age group.
B) The nurse would instruct the parents to keep medications out of the children's reach. Medication poisoning happens easily with young toddlers and preschool-age children who think the medication is candy.
C) A lack of a helmet next to a bike does not mean there are no helmets in the house. This finding would cause the nurse to ask more questions but is not considered a definite safety risk.
D) Child locks are appropriate to keep toddlers from wandering out to the street.

Page Ref: 2874-2875

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Communicate potential risk factors and actual errors. | Nursing Process: Assessment

Learning Outcome: 51.A. Analyze health promotion and injury prevention across the lifespan as they relate to safety. Outline the risk for injury, health promotion, and injury prevention for toddlers and preschoolers.

MNL LO: Analyze the concept of safety and its application to nursing care.

4) The home health nurse is talking with the parents outside the bathroom door while their 1-year-old twins are playing in the tub. Which client statement would require further safety teaching?
A) "Why don't we talk in the living room?"
B) "Let me get the children out of the tub so we can talk."
C) "I do not like to leave the children alone in the bathroom."
D) "I often bathe the children together."
Answer: A
Explanation: A) Infants and toddlers are at risk for drowning, even in small amounts of water. The nurse would want to teach the parent that it is never appropriate to leave young children unsupervised in the tub.
B) Taking the children out of the tub demonstrates an awareness of risk.
C) Not wanting to leave toddlers alone in the bathroom demonstrates an awareness of risk.
D) There is no risk with bathing the children together.
Page Ref: 2873
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Evaluation
Learning Outcome: 51.A. Analyze health promotion and injury prevention across the lifespan as they relate to safety. Outline the risk for injury, health promotion, and injury prevention for toddlers and preschoolers.

MNL LO: Analyze the concept of safety and its application to nursing care.

5) Reducing the risk of functional decline in older adults can help prevent which complication?
A) Pressure injuries
B) Macular degeneration
C) Hyperglycemia
D) Hearing loss
Answer: A
Explanation: A) By reducing the risk of functional decline, nurses and independent older adults can help prevent complications such as pressure injuries, delirium and depression, decreased mobility, loss of independence, and incontinence.
B) Macular degeneration is not a complication that occurs as a result of functional decline.
C) Hyperglycemia is not a complication that occurs as a result of functional decline.
D) Hearing loss is not a complication that occurs as a result of functional decline.
Page Ref: 2879
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 51.A.5. Analyze health promotion and injury prevention across the lifespan as it relates to safety. Outline the risks for injury, health promotion, and injury prevention for older adults.
MNL LO: Analyze the concept of safety and its application to nursing care.

6) The nurse is assessing a 12-year-old male client. The client is within the normal range for height, weight, and body mass index (BMI) for his age. The client plans to play contact sports at school this year. He lives with his mother and attends after-school events when she is working late. Which education should the nurse identify as a priority for this client to promote safety?

A) The importance of learning how to feel secure when he is at home alone

B) The importance of maintaining a normal weight and participating in physical activity

C) The importance of using safety equipment when playing contact sports

D) The importance of good hygiene practices and healthy diet

Answer: C

Explanation: A) Promoting a sense of security is important for latchkey children, but this client does not appear to be home alone for extended periods based on participation in school, sports, and after-school activities.

B) The client already has a normal weight and participates in physical activity, so education related to these topics is not as important as sports safety.

C) The client's biggest safety risk is a risk of injury from contact sports. The nurse should encourage the client to use proper safety equipment to avoid injury.

D) There is no evidence that this client has poor hygiene or an unhealthy diet.

Page Ref: 2877

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: QSEN Competencies: I.A.6. Describe strategies to empower patients or families in all aspects of the healthcare process. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 51.A.3. Analyze health promotion and injury prevention across the lifespan as it relates to safety. Contrast the risks for injury, health promotion, and injury prevention for school-age children and adolescents.

MNL LO: Analyze the concept of safety and its application to nursing care.

7) The nurse is caring for a 43-year-old client. Which education should the nurse provide to best address the disease prevention and health promotion needs of someone in this age group?
A) Teach the client about ergonomic aids for computer use
B) Teach the client about age-appropriate medical screenings
C) Tell the client to seek medical help for injuries
D) Encourage the client to not drive while distracted
Answer: B
Explanation: A) Teaching the client about ergonomic aids for computer use is a method to prevent injury, not disease.
B) The nurse can provide education in many areas related to disease prevention, including teaching about age-appropriate medical screenings.
C) Telling the client to seek medical help for injuries is a method to prevent injury, not disease.
D) Encouraging the client to not drive while distracted is a method to prevent injury, not disease.
Page Ref: 2878
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.6. Describe strategies to empower patients or families in all aspects of the healthcare process. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 51.A.4. Analyze health promotion and injury prevention across the lifespan as it relates to safety. Summarize the risks for injury, health promotion, and injury prevention for young and middle-aged adults.
MNL LO: Analyze the concept of safety and its application to nursing care.

8) The nurse is providing care to a 12-year-old child with special needs and his caregiver. Which strategy should the nurse teach the child to aid with safety?
A) How to schedule routine immunizations
B) How to use a telephone to call for help
C) Ways to maintain the airway with suctioning
D) Reason to avoid secondhand smoke exposure
Answer: B
Explanation: A) The caregiver would need instruction on scheduling routine immunizations and not the client.
B) For children with special needs, the caregiver can work with the child to teach the child how to use a telephone to call for help when needed.
C) The caregiver would need instruction on actions to maintain the airway and not the client.
D) The caregiver would benefit from teaching on reasons to avoid secondhand smoke and not the client.
Page Ref: 2879-2881
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.A.6. Describe strategies to empower patients or families in all aspects of the healthcare process. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 51.A.6. Analyze health promotion and injury prevention across the lifespan as it relates to safety. Plan nursing interventions for health promotion and injury prevention for individuals with special needs.

MNL LO: Analyze the concept of safety and its application to nursing care.

Exemplar 51.B Patient Safety

1) The nurse is assessing the hospital environment in order to decrease the risk for client falls. Which intervention should the nurse implement to decrease the risk of client falls?

A) Encourage the client to wear diapers.

B) Read label directions.

C) Lower side rails on client beds.

D) Clean the environment of clutter.

Answer: D

Explanation: A) Encouraging the client to wear diapers would increase functional decline, and it is not an appropriate strategy to help reduce falls.

B) Reading label directions will prevent the wrong use of substances given to the client but would not directly prevent falls.

C) Lowering side rails on client beds would increase the risk of falls.

D) Keeping the environment tidy and free of clutter will go a long way in preventing falls.

Page Ref: 2883

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: QSEN Competencies: V.B.1.Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation

Learning Outcome: 51.B. Analyze safety as it relates to patients in home care and healthcare settings. Write safety nursing interventions for patients in healthcare settings.

MNL LO: Analyze the concept of safety and its application to nursing care.

2) A client in the intensive care unit is combative and pulling at the endotracheal tube, which must remain in place. After exhausting all alternatives, the nurse applies soft restraints to protect the client's airway. Which action should the nurse take next?

A) Notify the primary healthcare provider.
B) Notify the family of the need for restraints.
C) Reassess the need for the restraints in 8 hours.
D) Document the application of restraints in the chart.

Answer: A

Explanation: A) Restraints can only be applied under the order of a physician. When there is an urgency to protect the client and others, restraints can be applied and then the physician should be notified immediately to write an order for the restraints.

B) The nurse would notify the family if present, but that is not the legal priority.

C) Most agencies require reassessment of need every 1-2 hours.

D) The nurse would document the use of restraints as soon as possible after notifying the primary healthcare provider.

Page Ref: 2884

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Policies and procedures. | Nursing Process: Implementation

Learning Outcome: 51.B. Analyze safety as it relates to patients in home care and healthcare settings. Write safety nursing interventions for patients in healthcare settings.

MNL LO: Analyze the concept of safety and its application to nursing care.

3) The nurse is developing a plan of care for a client who is at risk for falls. Which interventions would be appropriate for the nurse to include in the plan of care? **Select all that apply.**

A) Apply physical restraints if the client gets out of bed.
B) Assess the client's vision and make sure prescribed eyewear is worn.
C) Use side rails on client's bed.
D) Keep frequently used items within easy reach.
E) Provide slippers for the client to wear while ambulating.

Answer: B, C, D

Explanation: A) It is not appropriate for the nurse to apply physical restraints if the client gets out of bed.

B) Assessing the client's vision and making sure prescribed eyewear is worn is an appropriate action. Poor and blurry vision increases the client's risk of falling.

C) Using side rails on the client bed to prevent falls while the client is sleeping is an appropriate intervention.

D) It is appropriate to keep frequently used items within easy reach in an effort to prevent falls.

E) The nurse should ensure that the client wears shoes with adequate traction while ambulating. Slippers may increase the risk for falls.

Page Ref: 2883-2884

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality & Safety: Current best practices. | Nursing Process: Planning

Learning Outcome: 51.B. Analyze safety as it relates to patients in home care and healthcare settings. Write safety nursing interventions for patients in healthcare settings.

MNL LO: Analyze the concept of safety and its application to nursing care.

4) The staff nurses are discussing interventions to reduce the risk of infection for the client population. Which intervention is the most important to decrease client infection?
A) Practice appropriate hand hygiene.
B) Assess vital signs once daily.
C) Raise the temperature in the client's room.
D) Wear a mask for all client care.
Answer: A
Explanation: A) Hand hygiene is always the first and best way to stop the spread of microorganisms, which cause infections.
B) Assessing vital signs is important but should be done more frequently than once daily.
C) Raising the temperature in a client's room would contribute to the growth of microorganisms.
D) Wearing a mask for all clients is not practical and is unnecessary unless a microorganism is airborne and the client is in isolation.
Page Ref: 2884
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Policies and procedures. | Nursing Process: Implementation
Learning Outcome: 51.B. Analyze safety as it relates to patients in home care and healthcare settings. Write safety nursing interventions for patients in healthcare settings.
MNL LO: Analyze the concept of safety and its application to nursing care.

5) While reviewing safety precautions with the staff in a long-term care facility, which step should the nurse emphasize that helps to promote a safe environment for the clients?
A) Keep clutter out of the hallway and inside the client's room.
B) Provide dim lighting.
C) Turn off alarms to reduce noise.
D) Have the client wear shoes with rubber, skid-resistant soles.
Answer: D
Explanation: A) Both the hallways and the clients' rooms should be clutter free.
B) Dim lighting will increase the risk of client falls.
C) Noise should be kept to a minimum, but turning off alarms would endanger clients.
D) Having the client wear shoes with rubber, skid-resistant soles is the most appropriate intervention to decrease the risk of client falls, which will promote a safe environment.
Page Ref: 2883-2884
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Current best practices. | Nursing Process: Planning
Learning Outcome: 51.B. Analyze safety as it relates to patients in home care and healthcare settings. Write safety nursing interventions for patients in healthcare settings.
MNL LO: Analyze the concept of safety and its application to nursing care.

6) A novice nurse has accepted a position on a medical-surgical unit at a local university hospital. In order to provide safe care to clients, the nurse should plan to develop which competency?

A) Creating a culture of trust within the hospital
B) Functioning as a member of the healthcare team
C) Promoting appropriate values that clients should adopt
D) Reporting families for bringing food to the client's room

Answer: B

Explanation: A) Creating a culture of trust is a system change that is implemented by the administration.

B) New nurses should learn about the healthcare team members and determine whom to collaborate with in certain situations.

C) The nurse would respect the values of clients and not seek to impose any on the clients.

D) Rather than reporting families, the nurse would work with families to help meet their needs if food is not allowed in the room.

Page Ref: 2871

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: QSEN Competencies: V.A.5. Describe factors that create a culture of safety (such as, open communication strategies and organizational error reporting systems). | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Communicate effectively with different individuals (team members, other care providers, patients, families, etc.) so as to minimize risks associated with handoffs among providers and across transitions in care. | Nursing Process: Planning

Learning Outcome: 51.B. Analyze safety as it relates to patients in home care and healthcare settings. Write safety nursing interventions for patients in healthcare settings.

MNL LO: Analyze the concept of safety and its application to nursing care.

7) Which nursing intervention is appropriate for a client with dry and cracked feet?
A) Provide slippers for the client to wear at all times
B) Soak the client's feet in water several times daily
C) Apply lotion to the client's feet after bathing
D) Massage the client's feet daily
Answer: C
Explanation: A) Providing slippers will not heal dry and cracked feet.
B) Soaking the client's feet in water without any added moisturizers may make the client's condition worse.
C) For clients with dry and cracked feet, the nurse should apply lotion to the client's feet after the client's bathing time.
D) Massaging the client's feet will not heal dry and cracked feet.
Page Ref: 2887
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 2.6 Demonstrate accountability for care delivery. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 51.B. Analyze safety as it relates to patients in home care and healthcare settings. Plan nursing interventions for quality safety and best patient outcomes.
MNL LO: Analyze the concept of safety and its application to nursing care.

8) A client who is living independently but needs skilled nursing services may take advantage of which type of healthcare?
A) Long-term care
B) Home healthcare
C) Telehealth
D) Assisted living
Answer: B
Explanation: A) One aspect of long-term care is skilled nursing services, but the clients do not live independently.
B) Home healthcare provides a variety of medical, therapeutic, and nonmedical services, such as wound care, dietary counseling, physical therapy, occupational therapy, skilled nursing services, and homemaker services. These services are available in private homes from healthcare professionals.
C) Telehealth would not be adequate for providing skilled nursing services.
D) Assisted living facilities do not typically include skilled nursing services.
Page Ref: 2882
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Current best practices. | Nursing Process: Implementation
Learning Outcome: 51.B. Analyze safety as it relates to patients in home care and healthcare settings. Evaluate the quality of safety in home care settings.
MNL LO: Analyze the concept of safety and its application to nursing care.

9) The nurse is caring for a 3-year-old child who is in the hospital for the first time. The child appears frightened and is clinging to the parents. Which action can the nurse take to help the child feel more secure if the child needs to stay at the hospital without the parents?
A) Stay with the child when the parents go home
B) Have the parents bring comfort items from home to leave with the child
C) Keep dangerous medications and equipment out of the child's reach
D) Make sure the child wears proper identification at all times
Answer: B
Explanation: A) Having the nurse stay with the child at all times once the parents have left is not practical and could cause harm to other clients under the nurse's care.
B) To help a child feel more secure, the nurse can suggest that parents bring in a few comfort items the child is familiar with, such as photos, a favorite blanket, or a favorite toy.
C) Although the nurse should keep dangerous medications and equipment out of the child's reach, these actions will likely not help the child feel more secure.
D) Making sure the child wears proper identification at all times will not help the child feel more secure.
Page Ref: 2886
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: I.B.3. Provide patient-centered care with sensitivity and respect for the diversity of human experience. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Relationship Centered Care: The role of family, culture, and community in a person's development. | Nursing Process: Implementation

Learning Outcome: 51.B. Analyze safety as it relates to patients in home care and healthcare settings. Contrast safety lifespan considerations in healthcare settings.
MNL LO: Analyze the concept of safety and its application to nursing care.

10) A pregnant client with type 2 diabetes asks how medication will affect the fetus. Which response should the nurse make?
A) "The medications you are taking will not adversely affect your fetus. You should continue taking them as you did before your pregnancy."
B) "The medications you are taking have a risk of causing fetal defects. You should stop taking your medications while you are pregnant."
C) "The medications you are taking will not work as well when you are pregnant, so you should increase the dose of your medications."
D) "If you have any concerns about how your medication will affect your fetus, you should talk to your primary care physician."
Answer: D
Explanation: A) Encouraging the client to continue with the present treatment plan after a major change in health status is outside the nursing scope of practice.
B) Encouraging the client to stop taking medications is outside the nursing scope of practice.
C) Encouraging the client to change medication dosages is outside the nursing scope of practice.
D) If the client has concerns about medications, questions should be directed to the primary care physician or other provider. Depending on the medication and the client's health status, the provider may recommend increasing, decreasing, or stopping treatment during pregnancy, or the client may continue the present treatment plan. However, the nurse can reinforce any teaching provided by the physician.
Page Ref: 2886
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.2. Demonstrate effective use of strategies to reduce risk of harm to self or others. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Teamwork: Impact of team functioning on safety and quality of care, and how authority gradients influence teamwork and patient safety. | Nursing Process: Implementation

Learning Outcome: 51.B. Analyze safety as it relates to patients in home care and healthcare settings. Contrast safety lifespan considerations in healthcare settings.
MNL LO: Analyze the concept of safety and its application to nursing care.

Exemplar 51.C Nurse Safety

1) Which action by a nurse would require immediate intervention by another healthcare team member?
A) Recapping a needle using the scoop method.
B) Recapping a needle with the use of a hemostat.
C) Recapping a needle while holding the cap.
D) Disposing of a needle in the sharps container.
Answer: C
Explanation: A) If sharps do need to be recapped, this should be done with the scoop method.
B) If sharps do need to be recapped, this should be done with the use of another device (such as a hemostat).
C) Nurses should never hold the cap in one hand while trying to guide the tip of the needle into the cap with the other—this method substantially increases the risk of a sharp-related injury.
D) When working with used or contaminated sharps, nurses will employ extra precautions so as to avoid unnecessary injuries. Needles that have been used will be disposed of in an appropriate sharps container.
Page Ref: 2890
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.4. Communicate observations or concerns related to hazards and errors to patients, families and the healthcare team. | AACN Domains and Competencies: 5.3 Contribute to a culture of provider and work environment safety. | NLN Competencies: Quality and Safety: Policies and procedures. | Nursing Process: Implementation
Learning Outcome: 51.C. Analyze safety as it relates to being a nurse. Summarize strategies to prevent injury in nursing practice.
MNL LO: Analyze the concept of safety and its application to nursing care.

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2) A complaint about unsafe working conditions should be reported to which agency?
A) Occupational Safety and Health Administration
B) National Institute for Occupational Safety and Health
C) State board of nursing
D) American Nurses Association
Answer: A
Explanation: A) OSHA enforces the rights of workers to have a safe work environment. Therefore, complaints about unsafe work conditions should be filed with OSHA.
B) NIOSH conducts research to provide advances in safety.
C) State boards of nursing ensure that nurses are prepared and competent to provide safe nursing care.
D) The American Nurses Association is a professional organization for nurses.
Page Ref: 2888
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.A.5. Describe factors that create a culture of safety (such as, open communication strategies and organizational error reporting systems). | AACN Domains and Competencies: 5.3 Contribute to a culture of provider and work environment safety. | NLN Competencies: Quality and Safety: Promote communication and open reporting as a priority in healthcare. | Nursing Process: Implementation
Learning Outcome: 51.C. Analyze safety as it relates to being a nurse. Outline the agencies that regulate workplace safety for nurses.
MNL LO: Analyze the concept of safety and its application to nursing care.

3) The nurse working in a healthcare setting is charged with inappropriate delegation after asking an unlicensed assistive personnel (UAP) to change the IV bag for a client. To which agency should this action be reported?
A) Board of nursing
B) Occupational Health Safety Network
C) Occupational Health and Safety Administration
D) Health Hazard Evaluation Program
Answer: A
Explanation: A) The state board of nursing has established procedures for reporting errors and violations made by licensed nurses and acts to investigate those reports. Complaints can include unsafe nursing practices, such as inappropriate delegation.
B) The Occupational Health Safety Network does not investigate nursing errors.
C) OSHA does not investigate nursing errors.
D) The Health Hazard Evaluation Program does not investigate nursing errors.
Page Ref: 2888
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.A.5. Describe factors that create a culture of safety (such as, open communication strategies and organizational error reporting systems). | AACN Domains and Competencies: 5.3 Contribute to a culture of provider and work environment safety. | NLN Competencies: Quality and Safety: Communicate potential risk factors and actual errors. | Nursing Process: Implementation
Learning Outcome: 51.C. Analyze safety as it relates to being a nurse. Outline the agencies that regulate workplace safety for nurses.
MNL LO: Analyze the concept of safety and its application to nursing care.

4) A hospital has had higher than average reports of client handling and movement injuries. For which change should the nurse advocate that could most help reduce the number of client handling injuries?
A) Keep the clients restricted to bed
B) Encourage clients to lose weight
C) Hire more nurses
D) Purchase lifting devices
Answer: D
Explanation: A) Keeping the clients stationary would increase complications and slow the healing process.
B) Encouraging clients to lose weight would not reduce injuries.
C) Unless the hospital is understaffed, hiring more nurses would not help reduce injuries. Instead, nurses need to form lift teams to help reduce injuries.
D) Resources such as lifting devices, training, and lift teams can potentially reduce the number of occupational injuries of healthcare workers.
Page Ref: 2889
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 5.3 Contribute to a culture of provider and work environment safety. | NLN Competencies: Quality and Safety: Use technologies that contribute to safety. | Nursing Process: Implementation
Learning Outcome: 51.C. Analyze safety as it relates to being a nurse. Describe the etiology and prevalence of injuries to nurses.
MNL LO: Analyze the concept of safety and its application to nursing care.

5) The home healthcare nurse is traveling to a client's home for the first time. Which observation would suggest a safety hazard for the nurse?
A) Neighbor walking a dog on a leash
B) Porch steps that are broken and rotting
C) Client medications on the kitchen counter
D) Absence of streetlights in the neighborhood
Answer: B
Explanation: A) Unrestrained and hostile animals may pose a safety threat, but a neighbor walking a dog on a leash is not a safety hazard for the nurse.
B) Unhygienic or dangerous surroundings, such as broken and rotting porch steps, may pose a safety hazard for the nurse.
C) Client medications on the kitchen counter may be a safety hazard if small children are present in the home, but this does not pose a safety hazard for the nurse.
D) The nurse should only make home visits during daylight hours to maintain safety, so the absence of streetlights in the neighborhood should not affect the nurse.
Page Ref: 2892
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.A.4. Delineate general categories of errors and hazards in care. | AACN Domains and Competencies: 5.3 Contribute to a culture of provider and work environment safety. | NLN Competencies: Quality and Safety: Communicate potential risk factors and actual errors. | Nursing Process: Implementation
Learning Outcome: 51.C. Analyze safety as it relates to being a nurse. Summarize strategies to prevent injury in nursing practice.
MNL LO: Analyze the concept of safety and its application to nursing care.

6) An experienced nurse has accepted a new position in the mental health unit after working in the medical-surgical floor for the past 4 years. Which training would be beneficial for the nurse to refresh before starting her new position?
A) Using respirators
B) Preventing needlestick injuries
C) Managing aggressive behaviors
D) Lifting and moving clients
Answer: C
Explanation: A) Knowing how to use a respirator is more important for an infectious disease unit, not a mental health unit.
B) Because of experience on the medical-surgical unit, the nurse is already likely familiar with how to prevent needlestick injuries.
C) The nurse is exposed to a higher risk of injuries from assaults by clients or their families in a mental health unit compared to a medical-surgical unit. Therefore, the nurse may benefit from receiving training related to managing aggressive behaviors.
D) Because of experience on the medical-surgical unit, the nurse is already likely familiar with how to safely lift and move clients.
Page Ref: 2891-2892
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.4. Communicate observations or concerns related to hazards and errors to patients, families, and the healthcare team. | AACN Domains and Competencies: 5.3 Contribute to a culture of provider and work environment safety. | NLN Competencies: Knowledge and Science: Relationships between knowledge/science and quality and safe patient care. | Nursing Process: Implementation
Learning Outcome: 51.C. Analyze safety as it relates to being a nurse. Summarize strategies to prevent injury in nursing practice.
MNL LO: Analyze the concept of safety and its application to nursing care.

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7) The nurse is caring for a 230-lb client who needs to be repositioned every 2 hours. While repositioning the client, the nurse injured a back muscle. To prevent the injury and ensure safety for both the nurse and client, which action should the nurse have taken in this situation?
A) Used proper lifting techniques.
B) Repositioned the client only if the client requested it.
C) Questioned the physician about the need to reposition the client.
D) Asked for help from another nurse.
Answer: D
Explanation: A) There is no evidence that the nurse was not already using proper lifting techniques.
B) The nurse should reposition the client as ordered, not only when the client requests it.
C) The nurse should question physician orders if unclear about the reasoning for the order, but this is a standard best practice and would likely not require questioning.
D) When moving or repositioning clients, especially larger clients, the nurse should always ask for help from another healthcare worker to prevent injury.
Page Ref: 2890-2891
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 5.3 Contribute to a culture of provider and work environment safety. | NLN Competencies: Quality and Safety: Current best practices. | Nursing Process: Implementation
Learning Outcome: 51.C. Analyze safety as it relates to being a nurse. Summarize strategies to prevent injury in nursing practice.

MNL LO: Analyze the concept of safety and its application to nursing care.

Exemplar 51.D Medication Safety

1) The nurse is caring for a client diagnosed with a new health problem. For which reason should the nurse anticipate pharmacotherapy being prescribed for this client?
A) Cure the illness or relieve the symptoms
B) Determine how the client's body will react to the medication
C) Measure how much of the medication is excreted from the body
D) Monitor how the medication will be distributed throughout the body
Answer: A
Explanation: A) Pharmacotherapy is the treatment of diseases and medical conditions using pharmaceutical drugs. Medication therapy may be used to cure an illness or relieve symptoms.
B) Determining how the client's body will react to the medication is a process of pharmacokinetics.
C) Measuring how much of the medication is excreted from the body is a process of pharmacokinetics.
D) Monitoring how the medication will be distributed throughout the body is a process of pharmacokinetics.
Page Ref: 2894
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Current best practices. | Nursing Process: Planning
Learning Outcome: 51.D. Analyze medical administration as it relates to safety. Differentiate among pharmacokinetics, pharmacodynamics, and pharmacotherapy.
MNL LO: Analyze the concept of safety and its application to nursing care.

2) The nurse completes a medication reconciliation with an older client prescribed medication for chronic pain. For which reason should the nurse suspect that the client continues to rate pain as 8 on a scale from 1 to 10?
A) Medication is being rapidly excreted
B) Medication dose needs to be adjusted
C) Absorption of the medication is altered
D) Difficulty opening the medication containers
Answer: D
Explanation: A) It is unlikely that the medication is being rapidly excreted as excretion might be delayed in the older adult.
B) Additional information is needed before determining if the medication dose needs to be adjusted.
C) The effects of the medication would last longer if the absorption was altered in an older adult.
D) The nurse needs to find out if the client is taking the medication. An older adult might have difficulty opening the medication containers. It is possible that the client is not taking the medication which would explain the pain rating as 8.
Page Ref: 2894
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Current best practices. | Nursing Process: Assessment
Learning Outcome: 51.D. Analyze medical administration as it relates to safety. Analyze strategies nurses use to promote safe medication administration across care settings and for patients taking medications at home.
MNL LO: Analyze the concept of safety and its application to nursing care.

3) The nurse visits the home of a client with type 2 diabetes who continues to have elevated blood glucose levels despite being prescribed oral medications and a sliding scale for insulin coverage. Which observation indicates to the nurse that the client needs assistance with purchasing medications?

A) Insulin syringes in a container in the bathroom
B) Blood glucose monitor equipment in the bedroom
C) Oral medications placed in a medication organizer
D) Unfilled prescription for insulin found on a shelf in the kitchen

Answer: D

Explanation: A) Insulin syringes in a container in the bathroom would indicate that the medication has been obtained.

B) The blood glucose monitoring equipment in the bedroom would not help determine that the client needs assistance purchasing medications.

C) Oral medications in a medication organizer indicates that the prescription has been filled and the client is taking the medication.

D) Unfilled prescriptions found on a shelf in the kitchen indicates that the client is not taking the medication. It is likely that the client does not have the financial resources to purchase the insulin which would explain the consistently elevated blood glucose levels despite having a slide scale for insulin coverage.

Page Ref: 2900

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Current best practices. | Nursing Process: Assessment

Learning Outcome: 51.D. Analyze medical administration as it relates to safety. Examine current considerations in the nursing care of diverse groups of patients in need of pharmacotherapy.

MNL LO: Analyze the concept of safety and its application to nursing care.

4) The nurse visits the home of an older adult with several chronic illnesses. Which recommendation should the nurse make to ensure the client safely takes medications for the illnesses as prescribed?
A) Monitor the number of tablets in the containers
B) Use a kitchen spoon to take a liquid medication
C) Have someone supervise the client taking medication
D) Use the same pharmacy to have medication prescriptions filled
Answer: D
Explanation: A) Monitoring the number of tablets in the containers would be appropriate for an adolescent client.
B) The measuring device that comes with the liquid medication should be used and not a kitchen spoon.
C) Medication taking should be supervised for preschool and school-age children.
D) Older adults with several illnesses may have many medications to take. To help prevent accidentally taking medications that are incompatible with each other, a single pharmacy should be used to fill the prescriptions.
Page Ref: 2894
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: QSEN Competencies: V.B.1. Demonstrate effective use of technology and standardized practices that support safety and quality. | AACN Domains and Competencies: 5.2 Contribute to a culture of patient safety. | NLN Competencies: Quality and Safety: Current best practices. | Nursing Process: Implementation
Learning Outcome: 51.D. Analyze medical administration as it relates to safety. Describe strategies for ensuring safe medication use by patients across the lifespan.
MNL LO: Analyze the concept of safety and its application to nursing care.

Volume III

Clinical Nursing Skills: A Concept-Based Approach, 4e (Pearson)
Chapter 1 Assessment

1) A client on the medical/surgical unit complains of sudden chest pains. Which action will the nurse implement first?
A) Call the healthcare provider.
B) Administer pain medication.
C) Reassess a new set of vital signs.
D) Turn client from supine to lateral.
Answer: C
Explanation: A) The nurse will need to reassess the client first, before calling the healthcare provider.
B) The nurse will need to reassess the client first, before administering pain medication.
C) The nurse needs to implement a new set of vital signs first when there is a change in condition.
D) The nurse will need to reassess the client first, before moving the client, to avoid making the change in client's condition worse.
Page Ref: 2
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 1.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Relationship Centered Care

2) The nurse is observing the UAP taking the temperature of an unconscious client. Which route will the nurse question the UAP using?
A) Oral
B) Rectal
C) Scanner
D) Tympanic
Answer: A
Explanation: A) The temperature of an unconscious client is never taken by mouth. The rectal, tympanic, or scanner method is preferred.
B) The rectal, tympanic, or scanner method is preferred.
C) The rectal, tympanic, or scanner method is preferred.
D) The rectal, tympanic, or scanner method is preferred.
Page Ref: 24
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Evaluation | Learning Outcome: 1.1 | QSEN Competencies: Safety
AACN Domains and Comps.: Domain 5: Quality and Safety
NLN Competencies: Quality & Safety

3) The nurse is changing a 2-month-old client's diaper and notes the client feels warm to touch. Which method should the nurse use to check the baby's temperature?
A) Oral
B) Rectal
C) Axillary
D) Tympanic membrane
Answer: C
Explanation: A) Oral is used for age 3 or older.
B) The rectal route is the least desirable.
C) The axillary route may not be as accurate as other routes for detecting fevers in children.
D) The tympanic membrane may be used for 3 months or older.
Page Ref: 29
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Evaluating | Learning Outcome: 1.2 | QSEN Competencies: Safety
AACN Domains and Comps.: Domain 5: Quality and Safety
NLN Competencies: Quality & Safety

4) A client comes in with exacerbation of chronic obstructive pulmonary disease (COPD). Which noninvasive diagnostic test will the nurse implement to know that the client is receiving enough oxygen?
A) Chest x-ray
B) Pulse oximeter
C) Arterial blood gasses
D) Assessment of respiratory rate
Answer: B
Explanation: A) A chest x-ray is not an intervention a nurse completes.
B) A pulse oximeter provides a noninvasive method of measuring oxygenation, or oxygen saturation, in the blood and provides a pulse reading, which is especially helpful for the client with a respiratory illness or disease.
C) Arterial blood gases are an invasive diagnostic test.
D) Assessing a respiratory rate is important for the nurse to implement; however, it is not a diagnostic test.
Page Ref: 21
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 1.3 | QSEN Competencies: Informatics
AACN Domains and Comps.: Domain 5: Quality and Safety
NLN Competencies: Quality & Safety

5) The nurse is preparing to assess a client's musculoskeletal system. Which question should the nurse ask before beginning this assessment?
A) "Do you exercise every day?"
B) "Do you have a history of any sports injuries?"
C) "Do you take a hot bath to relax your muscles?"
D) "Do you want pain medication before I begin?"
Answer: B
Explanation: A) Knowing if a client exercises is an important question but knowing if there are any sports injuries to know about first, is most important before doing a routine musculoskeletal assessment.
B) It is important to note if the client has a history of any sports injuries first to know what the client will or will not be able to do during a routine musculoskeletal assessment.
C) Knowing if the client takes a hot bath to relax the muscles is not the most important thing to ask before performing a routine musculoskeletal assessment.
D) To know if a client is experiencing any pain is an important question; however, this question is assuming the client is in pain by asking if the client wants a pain medication before beginning a routine musculoskeletal assessment.
Page Ref: 62
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 1.5 | QSEN Competencies: Safety
AACN Domains and Comps.: Domain 5: Quality and Safety
NLN Competencies: Quality & Safety

6) An adult child mentions that the client seems to have a decline in mental status and seems to be forgetting many things in their conversation since being hospitalized. Which response should the nurse make?
A) "Give your mom time, because it will take her a little longer when answering questions."
B) "Let me check the cranial nerve function to see if there is a defect in her mental status."
C) "You do not need to worry. This decline is part of the normal process of aging."
D) "If you bring some things from her home, it might reduce the confusion."
Answer: D
Explanation: A) This is expected to give some older adults time to respond, but the daughter is concerned about her forgetting, not the length of the response.
B) Cranial nerve function is an assessment of the cranial nerves and not the mental status of a client.
C) A decline in mental status is not a normal result of aging, so this response is not true.
D) The stress of being in unfamiliar situations can cause confusion in some older adults.
Page Ref: 75
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: Nursing Process: Planning | Learning Outcome: 1.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Context and Environment

7) When assessing breath sounds, the nurse hears moderate-intensity and moderate-pitch "blowing" sounds between the scapulae and lateral to the sternum at the first and second intercostal spaces. Which action should the nurse take?
A) Encourage the client to cough and deep breathe.
B) Notify the healthcare provider of abnormal breath sounds.
C) Document assessment findings as normal breath sounds.
D) Raise the head of the bed to allow maximum air excursion.
Answer: C
Explanation: A) There is no reason to encourage the client to take deep breaths and cough.
B) The nurse would notify the healthcare provider if these were adventitious lung sounds; however, these are bronchovesicular sounds.
C) These are bronchovesicular sounds.
D) The nurse would implement this if these were adventitious lung sounds; however, these are bronchovesicular sounds.
Page Ref: 88
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Context and Environment

8) A client seeks medical attention for shortness of breath and a fever. Which amount of time should the nurse count the peripheral pulse?

A) 15 seconds
B) 30 seconds
C) 1 minute
D) 2 minutes
Answer: C
Explanation: A) Count for a full minute if taking a client's pulse for the first time.
B) Count for a full minute if taking a client's pulse for the first time.
C) Count for a full minute if taking a client's pulse for the first time.
D) Count for a full minute if taking a client's pulse for the first time.
Page Ref: 19
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety

9) The nurse is preparing a dose of digoxin for a client. Which assessment will the nurse complete prior to giving this medication?

A) Temperature

B) Apical pulse

C) Respiratory rate

D) Pain using a pain scale

Answer: B

Explanation: A) The temperature does not need to be assessed before giving digoxin.

B) The nurse should assess the apical pulse before the administration of a medication that could affect the cardiovascular system, such as before giving a digitalis preparation.

C) The respiratory rate does not need to be assessed before giving digoxin.

D) Pain level does not need to be assessed before giving digoxin.

Page Ref: 18

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: Domain 5: Quality and Safety

NLN Competencies: Quality & Safety

10) The nurse is completing a general assessment of a newborn. Which technique should the nurse use?

A) Wrap the tape measure around the head below the ears.

B) Wrap the tape measure around the head starting at the nose.

C) Wrap the tape measure around the abdomen at the umbilicus.

D) Wrap the tape measure around the chest below the nipple line.

Answer: C

Explanation: A) When measuring the head circumference, wrap the tape around the head at the supraorbital prominence above the eyebrows, above the ears, and around the occipital prominence.

B) When measuring the head circumference, wrap the tape around the head at the supraorbital prominence above the eyebrows, above the ears, and around the occipital prominence.

C) When measuring the abdomen circumference, wrap the tape around the abdomen at the level of the umbilicus.

D) When measuring the chest circumference, wrap the tape measure around the chest, placed just under the axilla and at the nipple line.

Page Ref: 31

Cognitive Level: Applying

Client Need/Sub: Health Promotion and Maintenance

Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: Domain 2: Person-Centered Care

NLN Competencies: Quality & Safety

11) The nurse is measuring the blood pressure of an adult client. Which technique would cause an erroneously low blood pressure?

A) Bladder to cuff ratio too wide
B) Arm unsupported
C) Cuff wrapped too loosely
D) Arm below heart level
Answer: A
Explanation: A) The width of the bladder cuff needs to be 40% of the circumference or 20% wider than the diameter of the midpoint.
B) If the arm is unsupported, it will cause an erroneously high blood pressure.
C) If the cuff is wrapped too loosely, it will cause an erroneously high blood pressure.
D) If the arm is below heart level, it will cause an erroneously high blood pressure.
Page Ref: 11
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety

12) The nurse is reviewing collected data. Which client should the nurse see first?

A) Infant respirations 38/min
B) 2-year-old pulse 112/min
C) 6-year-old axillary temperature 97.5°F
D) 10-year-old blood pressure 138/88
Answer: D
Explanation: A) An infant's respiration range is 20-40/min.
B) A 2-year-old child's pulse range is 70-120/min.
C) A 6-year-old child's temperature range is 98.6°F but axillary is 1°F lower than oral.
D) A 10-year-old child's blood pressure range is systolic 95-116 and diastolic 60-70. This is much higher than the range for the age of this client.
Page Ref: 15
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety

13) The nurse is caring for a client with diaphoresis. Which route should the nurse use to assess the client's temperature? **Select all that apply.**
A) Oral
B) Rectal
C) Axillary
D) Tympanic
E) Heat sensitive
Answer: A, B, D
Explanation: A) Oral does not interfere with diaphoresis because the probe is in the mouth.
B) Rectal does not interfere with diaphoresis because the probe is in the rectum.
C) Axillary might be wet and cause an error in the reading temperature.
D) Tympanic does not interfere with diaphoresis because the probe is in the ear. However, do not use if ear is draining or infected.
E) Heat sensitive might have areas of the skin that are wet and cause an error in reading temperature.
Page Ref: 26, 28
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety

14) The nurse is preparing to assess a client's abdomen. Which response will the nurse make when asked why the stethoscope is warmed up before placing it on the abdomen?

A) "I might hear a friction rub with a cold stethoscope."
B) "A nice nurse will put a warm stethoscope on your abdomen."
C) "A cold stethoscope may cause your abdominal muscles to contract."
D) "Warming up the stethoscope will help with the digestion of your food."
Answer: C
Explanation: A) The nurse might hear a friction rub due to an inflammation, infection, or abdominal growth, not from a cold stethoscope.
B) Warming up a stethoscope can be nice for the client's comfort; however, it is done to decrease the possibility of abdominal muscles contracting; otherwise the nurse might hear unnecessary contractions.
C) A cold stethoscope may cause the abdominal muscles to contract which the nurse might hear with a cold stethoscope.
D) Warming up the stethoscope has no effect on the digestion of food. A warm stethoscope will decrease the possibility of abdominal muscles contracting, eliminating the possibility of the nurse hearing any unnecessary noises.
Page Ref: 31
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety

15) The nurse is preparing a teaching tool about gastrointestinal function. Which signs and symptoms of colon cancer will the nurse include on the tool? **Select all that apply.**
A) Weight gain
B) Rectal bleeding
C) Unusual cough
D) Change in bowel function
E) Decrease medication absorption
Answer: B, D
Explanation: A) Weight loss, not gain, is a sign and symptom of colon cancer.
B) Rectal bleeding is a symptom of colon cancer.
C) Unusual cough is more a sign and symptom of a lung infection or lung cancer.
D) A change in bowel function is a symptom of colon cancer.
E) A decrease in medication absorption often occurs with aging, not colon cancer.
Page Ref: 34
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety

16) The nurse needs to assess the ears of a 2-year-old client. Which technique will the nurse use?
A) Pull the pinna up and back.

B) Pull the pinna up and forward.
C) Pull the pinna down and back.
D) Pull the pinna down and forward.
Answer: C
Explanation: A) Pulling the pinna up and back will straighten the ear canal for a client greater than 3 years old.
B) Pulling the pinna up and forward will not allow sufficient visualization of the ear.
C) Pulling the pinna down and back will straighten the ear canal for a client less than 3 years old.
D) Pulling the pinna down and forward will not allow sufficient visualization of the ear.
Page Ref: 43
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety

17) The nurse is assessing an adolescent. Which finding indicates that the client is in Tanner's stage 5?
A) There is no pubic hair except for fine body hair.
B) Pubic hair is developing along the labia.
C) Pubic hair distribution extends to umbilicus.
D) Pubic hair appears on the inner aspect of the thigh.
Answer: D
Explanation: A) No pubic hair is Tanner Stage 1.
B) Pubic hair developing along the labia is Stage 2.
C) Pubic hair distribution extends to umbilicus is Stage 5 but for men only.
D) Pubic hair appears on the inner aspect of the thigh for Stage 5.
Page Ref: 51
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety

18) The UAP notifies the nurse of these vital signs for a client on the medical-surgical unit: temperature 97.6°F, respirations 22, pulse 122, and BP 98/72. mm Hg Which action should the nurse take?
A) Ask the UAP to reassess the client.
B) Inform the UAP to document these vital signs.

C) Reassess the client to validate these vital signs.
D) Notify the healthcare provider of these vital signs.
Answer: C
Explanation: A) UAP cannot assess or reassess as evaluation of data.
B) These vital signs are abnormal; the nurse needs to reassess the client to validate these findings.
C) The nurse needs to reassess the client to validate these findings.
D) The nurse will notify the healthcare provider of these vital signs after the nurse reassesses the client to validate these findings.
Page Ref: 2
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety

19) The nurse is assessing the Babinski response of an adult client. Which finding indicates that the response is negative?
A) All toes turn inward.
B) All toes curve upward.
C) All toes spread outward.
D) All toes bend downward.
Answer: D
Explanation: A) This is not in relation to the Babinski response; it could be another problem.
B) A positive Babinski response is when the toes spread outward and the big toe moves upward and backward.
C) A positive Babinski response is when the toes spread outward and the big toe moves upward and backward.
D) All toes bend downward for a negative Babinski response on an adult.
Page Ref: 70
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety

20) The nurse is preparing to assess an adult client's blood pressure. Which action will the nurse take after introducing self?
A) Provide privacy.
B) Perform handwashing.
C) Identify the client with two identifiers.
D) Explain what he or she will be doing with the client.
Answer: C
Explanation: A) Need to identify the right client before providing privacy so the correct room is located.
B) Need to identify the right client before performing handwashing so the correct room is located.
C) The nurse needs to identify the right client before doing anything else after introducing self.
D) The nurse needs to identify the right client before explaining the procedure so the client knows why the nurse is in the room.
Page Ref: 14
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety

21) The nurse is completing an assessment on a client who just received morphine. Which parameter is the highest priority?
A) Pain level
B) Respirations
C) Temperature
D) Blood pressure
Answer: B
Explanation: A) Pain level has already been assessed because the client just received morphine and it is too early to reassess pain.
B) Respirations are highest priority after administering morphine because morphine can cause respiratory depression.
C) The temperature of a client is not affected by morphine or pain.
D) Blood pressure can change because of the client's pain; however, the highest priority for this client is respirations because morphine was just administered.
Page Ref: 23
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Safety
AACN Domains and Comps.: Domain 5: Quality and Safety
NLN Competencies: Quality & Safety

22) The nurse receives information provided during hand-off communication. Which client will the nurse see first?

A) Kussmaul respirations
B) Blood glucose of 144 mg/dL
C) Pain level 6 out of 10
D) Temperature is 101.8°F
Answer: A
Explanation: A) This client is probably experiencing diabetic ketoacidosis or going into shock and needs to be reassessed immediately.
B) The glucose is elevated in this client, but the Kussmaul breathing has a higher priority.
C) The pain level is moderate pain.
D) The temperature is elevated, but Kussmaul breathing has a higher priority.
Page Ref: 91
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety

23) The nurse is reviewing the care needs of assigned clients. Which task can the nurse delegate to the UAP?
A) Administration of medication
B) Recording findings from a sponge bath
C) Teaching a client how to take own vital signs
D) Assessing a client in the medical-surgical unit for two days
Answer: B
Explanation: A) Administration of medication requires licensed personnel to administer.
B) A UAP can record the findings from a sponge bath because the skin is observed during a UAP's usual care.
C) UAPs cannot teach clients because this is outside their scope of practice.
D) Assessing is outside the UAP's scope of practice.
Page Ref: 79
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Safety
AACN Domains and Comps.: Domain 5: Quality and Safety
NLN Competencies: Quality & Safety

24) The nurse reviews applying a pulse oximeter with UAP. Which statement indicates teaching was effective?
A) "I will clean the site after applying the sensor."
B) "I will move the adhesive toe or finger sensor once a shift."
C) "I will remove any fingernail polish when using a pulse oximeter."
D) "I will use the side of the finger rather than perpendicular to the nail bed."
Answer: D
Explanation: A) The site needs to be cleaned before applying the sensor.
B) The adhesive toe or finger sensor needs to be moved every four hours.
C) The UAP needs to remove dark fingernail polish.
D) The side of the finger is an alternate use if the client has dark fingernail polish on the fingernail.
Page Ref: 21
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: Nursing Process: Assessment | Learning Outcome: 1.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: Domain 2: Person-Centered Care
NLN Competencies: Quality & Safety

WwW.TeSM.Ws

Clinical Nursing Skills: A Concept-Based Approach, 4e (Pearson)
Chapter 2 Caring Interventions

1) The nurse is observing a UAP performing a bed bath for a client. Which action by the UAP requires the nurse to intervene?
A) Washing the client's arms from wrists to shoulders.
B) Washing the client's eyes and face first before the rest of the body.
C) Washing, rinsing, and drying the client's leg from thigh to ankle.
D) Washing the client's back and then the perineum.
Answer: C
Explanation: A) The arms should be washed from wrist to shoulder.
B) The eyes and face should be washed before the rest of the body.
C) The correct method in performing a bed bath is washing, rinsing, and drying the client's leg from ankle to thigh.
D) The back is washed before the perineum.
Page Ref: 98-99
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Assessment | Learning Outcome: 2.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Relationship Centered Care

2) The nurse delegates soft contact lens care to a UAP. Which action by the UAP requires the nurse to intervene?
A) Placing the client in the semi-Fowler's position.
B) Placing the client's removed disposable lenses in the trash.
C) Placing the gloved thumb and forefinger directly on the soft lens on top of the eyeball.
D) Placing the gloved thumb on the client's lower eyelid and gloved index finger on the client's upper lid, pressing lightly on the eyeball.
Answer: D
Explanation: A) The client should be in the semi-Fowler position.
B) Disposable lens should be placed in the trash.
C) Pressure should not be applied directly on the soft lens covering the eyeball.
D) Placing the gloved thumb on the client's lower eyelid and gloved index finger on the client's upper lid, pressing lightly on the eyeball is the technique to remove rigid contact lenses, not soft lenses.
Page Ref: 110
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Intervention | Learning Outcome: 2.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Relationship Centered Care

3) The nurse determines some client care tasks can be delegated to the UAP. Which task should the nurse omit?
A) Performing foot care for a client with diabetes.
B) Changing an occupied bed for a client with multiple intravenous medications infusing.
C) Performing a bath for a newborn with an unhealed umbilical cord.
D) Oral care for an unconscious client.
Answer: A
Explanation: A) The registered nurse should perform foot care for the client with diabetes.
B) UAP can change an occupied bed.
C) UAP can provide a bath to a newborn with an unhealed umbilical cord.
D) UAP can provide oral care to an unconscious client.
Page Ref: 111
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Intervention | Learning Outcome: 2.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Relationship Centered Care

4) When teaching the client about foot care, which statement will the nurse include in the teaching?
A) "Use creams or lotions on the feet and in between the toes after showering."
B) "While sitting, cross your legs at the knees instead of the ankles."
C) "Avoid using pumice stones on the feet to decrease callouses."

D) "When your feet are cold, place them on a hot water bottle to warm them."
Answer: C
Explanation: A) Lotion or cream should be applied on the feet, avoiding the toes, after showering.
B) Legs should be crossed at the ankles.
C) The client should avoid using pumice stones on the feet because these can injure the feet.
D) Feet should not be placed on a hot water bottle as this could cause a burn.
Page Ref: 113
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Intervention | Learning Outcome: 2.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.8 Promote self-care management.
NLN Competencies: Relationship Centered Care

5) Prior to delegating hearing aid care to a UAP, what is the nurse's PRIORITY?
A) Determine the UAP's knowledge of the procedure.
B) Inform the UAP of what to report back to the nurse.
C) Discuss relevant client health information necessary for the task.
D) Provide the UAP with guidance on where to find supplies necessary for the task.
Answer: A
Explanation: A) Prior to delegation, the nurse must first determine the UAP's knowledge of the procedure.
B) Reporting back to the nurse can occur at the end of the procedure.
C) Client information is not essential when delegating hearing aid care.
D) The UAP should be provided with the supplies for the task.
Page Ref: 116
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Intervention | Learning Outcome: 2.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Quality & Safety

6) A client places one hearing aid in the ear and tells the nurse, "I hear a whistling sound." Which actions will the nurse take in response to the client's statement? **Select all that apply**.
A) Turn the volume of the hearing aid up.
B) Check the battery inside the hearing aid.
C) Turn the volume of the hearing aid down.
D) Ensure the ear canal is not blocked with wax.
E) Check that the earmold is attached to the receiver.
Answer: C, E
Explanation: A) Turning the volume up will make the whistling worse.
B) The battery does not need to be checked.
C) Turning the volume of the hearing aid down will decrease the client's distress.
D) Wax in the ear does not cause the hearing aid to whistle.
E) Checking that the earmold is attached to the receiver troubleshoots the whistling noise.
Page Ref: 117
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Intervention | Learning Outcome: 2.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Relationship Centered Care

7) The nurse cares for a client who receives new hearing aids for the first time. Which statements will the nurse include when teaching the client about the hearing aids? **Select all that apply**.
A) "Push the earmold slightly backward and pull out to remove it."
B) "Rotate the earmold slightly forward and pull out to remove it."
C) "If the hearing aid is not used for several days, be sure to turn the device off."
D) "If the earmold is detachable, soak it in isopropyl alcohol weekly to disinfect it."
E) "Blow any excess moisture through the opening of the earpiece when cleaning it."
Answer: B, E
Explanation: A) The hearing aid is not removed by pushing the earmold backward.
B) The nurse will instruct the client to rotate the earmold slightly forward and pull it out to remove it.
C) The battery should be removed if the device is not used for several days.
D) The earmold should not be soaked in alcohol.
E) To remove excess moisture, the client can be instructed to blow any excess moisture through the opening of the earpiece.
Page Ref: 116
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Intervention | Learning Outcome: 2.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Relationship Centered Care

8) The nurse is performing hearing aid care for a client and notes the hearing aid has "TM" near its on/off switch. What is the nurse's understanding of the meaning of "TM"?
A) Transmitting mode
B) Tympanic membrane
C) Telephone/microphone
D) Tympanic/microphone
Answer: C
Explanation: A) TM does not mean transmitting mode.
B) TM does not mean tympanic membrane.
C) "T/M" on the hearing aid stands for telephone/microphone, not tympanic membrane.
D) TM does not mean tympanic microphone.
Page Ref: 116
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Assessment | Learning Outcome: 2.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Quality & Safety

9) A nurse is providing oral care to an older adult. What findings does the nurse recognize are normal findings in this client? **Select all that apply**.
A) Dry mouth
B) Gingivitis
C) Jaw bone loss
D) Receding gums
E) Tooth root decay
Answer: A, D, E
Explanation: A) Dryness of the oral mucosa is a common finding among many older adults.
B) Gingivitis is not a common finding in an older adult.
C) Jaw bone loss is not a common finding in an older adult.
D) Receding gums is a common finding among many older adults.
E) Tooth root decay is common in some older adults, often due to receding gums.
Page Ref: 122
Cognitive Level: Remembering
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 2.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

10) The nurse is making an occupied bed. In which order should the nurse perform when removing the top linens and adding the bath blanket?
A) Spread the bath blanket over the top sheet.

B) Remove the spread and the blanket.
C) Reach under the bath blanket, grasp top edge of sheet.
D) Ask the client to hold the top edge of the bath blanket.
E) Pull the sheet from under the bath blanket.
Answer: B, A, D, C, E
Explanation: A) Spreading the bath blanket over the top sheet happens after the nurse removes the spread and blanket (top linens).
B) Removing the spread and blanket is the first step in the procedure.
C) After removing the spread and the blanket, spreading the bath blanket on the top sheet, asking the client to hold the top edge of the bath blanket, the nurse will reach under the bath blanket and grasp the top edge of the sheet.
D) After removing the spread and the blanket, spreading the bath blanket on the top sheet, the nurse will ask the client to hold the top edge of the bath blanket.
E) After removing the spread and the blanket, spreading the bath blanket on the top sheet, asking the client to hold the top edge of the bath blanket, the nurse will reach under the bath blanket and grasp the top edge of the sheet. Finally, the nurse will pull the sheet from under the bath blanket.
Page Ref: 104
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 2.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Quality & Safety

11) The nurse prepares to make an unoccupied bed. Place the steps in correct order of how the nurse will remove the soiled linens.
A) Detach the call bell and any drainage tubes from the bed linens.
B) Loosen all the bedding systematically.
C) Roll all soiled linens inside the bottom sheet.
D) Remove the incontinent pad and discard.
E) Remove the pillowcases and fold reusable linens.
Answer: A, B, E, D, C
Explanation: A) The first step to make an unoccupied bed is to detach the call bell and any drainage tubes from the bed linens.
B) The second step when making an unoccupied bed is loosening all the bedding systematically.
C) The final step when making an unoccupied bed is rolling all soiled linens inside the bottom sheet.
D) Removing the incontinent pad and discarding it occurs after detaching the call bell, loosening the bedding, and removing the pillowcases.
E) Removing the pillowcases occurs after detaching the call bell and loosening all bedding systematically.
Page Ref: 105
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 2.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Quality & Safety

12) The nurse prepares to perform oral care for a client with dentures. Place the steps in correct order for how the nurse will remove the client's dentures.
A) Use gauze to grasp upper plate at the front teeth with the thumb and second finger.
B) Lift the lower plate and remove without stretching the lip.
C) Move the denture up and down slightly.
D) Don gloves.
E) Place the upper plate in the denture cup.
F) Place the lower plate in the denture cup.
Answer: D, A, C, E, B, F
Explanation: A) The correct steps to remove the client's dentures is as follows: Don gloves, use gauze to grasp the upper plate at the front teeth with the thumb and second finger, move the denture up and down slightly, place the upper plate in the denture cup. Next, lift the lower plate and remove it without stretching the lip. Finally, place the lower plate in the denture cup.
B) The correct steps to remove the client's dentures is as follows: Don gloves, use gauze to grasp the upper plate at the front teeth with the thumb and second finger, move the denture up and down slightly, place the upper plate in the denture cup. Next, lift the lower plate and remove it without stretching the lip. Finally, place the lower plate in the denture cup.
C) The correct steps to remove the client's dentures is as follows: Don gloves, use gauze to grasp the upper plate at the front teeth with the thumb and second finger, move the denture up and down slightly, place the upper plate in the denture cup. Next, lift the lower plate and remove it without stretching the lip. Finally, place the lower plate in the denture cup.
D) The correct steps to remove the client's dentures is as follows: Don gloves, use gauze to grasp the upper plate at the front teeth with the thumb and second finger, move the denture up and down slightly, place the upper plate in the denture cup. Next, lift the lower plate and remove it without stretching the lip. Finally, place the lower plate in the denture cup.

E) The correct steps to remove the client's dentures is as follows: Don gloves, use gauze to grasp the upper plate at the front teeth with the thumb and second finger, move the denture up and down slightly, place the upper plate in the denture cup. Next, lift the lower plate and remove it without stretching the lip. Finally, place the lower plate in the denture cup.
F) The correct steps to remove the client's dentures is as follows: Don gloves, use gauze to grasp the upper plate at the front teeth with the thumb and second finger, move the denture up and down slightly, place the upper plate in the denture cup. Next, lift the lower plate and remove it without stretching the lip. Finally, place the lower plate in the denture cup.
Page Ref: 119
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 2.2 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

13) The nurse prepares to mix two medications (vial A and B) in one syringe. Place the steps in correct order for how the nurse will perform the procedure.
A) Inject a volume of air equal to the volume of medication to be withdrawn into vial A.
B) Withdraw the required amount of medication from vial B.
C) Draw up a volume of air equal to the volume of medications to be withdrawn from both vials A and B.
D) Withdraw the needle from vial A and inject the remaining air into vial B.
E) Withdraw the required amount of medication from vial A.
Answer: C, A, D, B, E
Explanation: A) Mixing two medications from two vials in one syringe has the following steps: After performing appropriate hand hygiene, draw up a volume of air equal to the volume of medications to be withdrawn from both vials A and B. Inject a volume of air equal to the volume of medication to be withdrawn into vial A. Next withdraw the needle from vial A and inject the remaining air into vial B. Withdraw the required amount of medication from vial B. Finally, withdraw the required amount of medication from vial A.
B) Mixing two medications from two vials in one syringe has the following steps: After performing appropriate hand hygiene, draw up a volume of air equal to the volume of medications to be withdrawn from both vials A and B. Inject a volume of air equal to the volume of medication to be withdrawn into vial A. Next withdraw the needle from vial A and inject the remaining air into vial B. Withdraw the required amount of medication from vial B. Finally, withdraw the required amount of medication from vial A.
C) Mixing two medications from two vials in one syringe has the following steps: After performing appropriate hand hygiene, draw up a volume of air equal to the volume of medications to be withdrawn from both vials A and B. Inject a volume of air equal to the volume of medication to be withdrawn into vial A. Next withdraw the needle from vial A and inject the remaining air into vial B. Withdraw the required amount of medication from vial B. Finally, withdraw the required amount of medication from vial A.

D) Mixing two medications from two vials in one syringe has the following steps: After performing appropriate hand hygiene, draw up a volume of air equal to the volume of medications to be withdrawn from both vials A and B. Inject a volume of air equal to the volume of medication to be withdrawn into vial A. Next withdraw the needle from vial A and inject the remaining air into vial B. Withdraw the required amount of medication from vial B. Finally, withdraw the required amount of medication from vial A.
E) Mixing two medications from two vials in one syringe has the following steps: After performing appropriate hand hygiene, draw up a volume of air equal to the volume of medications to be withdrawn from both vials A and B. Inject a volume of air equal to the volume of medication to be withdrawn into vial A. Next withdraw the needle from vial A and inject the remaining air into vial B. Withdraw the required amount of medication from vial B. Finally, withdraw the required amount of medication from vial A.
Page Ref: 134
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 2.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Quality & Safety

14) The nurse delegates oral care of an unconscious client on supplemental oxygen to the UAP. Which action by the UAP requires the nurse to intervene?
A) Placing a bite block in the client's mouth.
B) Applying petroleum-based moisturizer to the client's lips.
C) Positioning the client in side-lying position with head of bed lowered.
D) Using a separate moistened swab for the inside of each cheek.
Answer: B
Explanation: A) A bite block should be used.
B) Applying petroleum-based moisturizer to the client's lips will require nursing intervention because these products may increase the risk of fire for clients with oxygen. Water-based moisturizers should be used instead.
C) The client should be in the side-lying position with the head of the bed lowered.
D) A separate moistened swab should be used for the inside of each cheek.
Page Ref: 117
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 2.2 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

15) The nurse understands that, in addition to the five client rights of medication administration, there are now more rights for safe medication administration. Which rights are the new rights for safe medication administration? **Select all that apply**.

A) Right documentation
B) Right dose
C) Right time
D) Right route
E) Right reason
Answer: A, E
Explanation: A) Right documentation is a new right for safe medication administration.
B) Right dose has been a right for safe medication administration.
C) Right time has been a right for safe medication administration.
D) Right route has been a right for safe medication administration.
E) Right reason is a new right for safe medication administration.
Page Ref: 128
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 2.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

16) The nurse is acting as preceptor for a novice nurse. Which action by the novice nurse requires the nurse preceptor to intervene?
A) Labeling medications placed in a medication cup.
B) Removing prepackaged medication and placing in a medication cup.
C) Keeping narcotics separated from other medications that need to be administered.
D) Breaking scored tablets as needed for correct dosage.
Answer: B
Explanation: A) Medications placed in a cup should be labeled.
B) The nurse should leave prepackaged medications in their original package to ensure proper labeling and to maintain sanitary approaches.
C) Narcotics should be kept separate from other medications.
D) Scored tablets should be broken for the correct dosage.
Page Ref: 151
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 2.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

17) The nurse performs a skin assessment while bathing an older adult client. Which lifespan considerations regarding skin characteristics are more common in the older adult? **Select all that apply**.
A) Dry skin

B) Itchy skin
C) Poor healing
D) Increased risk of water retention
E) Increased risk of trauma
Answer: A, B, C, E
Explanation: A) The older adult client is at increased risk for dry skin due to a decrease in endocrine secretion and decreased elastin.
B) The older adult client is at increased risk for itchy skin due to a decrease in endocrine secretion and decreased elastin.
C) The older adult client is at increased risk for poor healing due to inadequate nutrition, compromised immunity, poor hydration, and decreased mobility, among other factors.
D) The older adult client is not at risk for water retention.
E) The older adult client is at increased risk of trauma due to fall, immobility, and decreased ability to heal, among others.
Page Ref: 102
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 2.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Relationship Centered Care

18) The nurse prepares to administer an intermittent intravenous solution using a secondary administration set. Place the steps of assembling the secondary infusion in correct order.
A) Insert the secondary tubing needleless cannula into the distal primary tubing port located above the infusion pump.
B) Hang the secondary container above the level of the primary bag.
C) Attach the appropriate label to the secondary tubing.
D) Lower medication bag to clear tubing and back-prime tubing.
E) Close the clamp on the secondary infusion tubing and spike the medication infusion bag.
Answer: E, A, B, D, C
Explanation: A) The correct steps of assembling the secondary infusion is as follows: Close the clamp on the secondary infusion tubing and spike the medication infusion bag; insert the secondary tubing needleless cannula into the distal primary tubing port located above the infusion pump; hang the secondary container above the level of the primary bag; lower medication bag to clear tubing and back-prime tubing; attach the appropriate label to the secondary tubing.
B) The correct steps of assembling the secondary infusion is as follows: Close the clamp on the secondary infusion tubing and spike the medication infusion bag; insert the secondary tubing needleless cannula into the distal primary tubing port located above the infusion pump; hang the secondary container above the level of the primary bag; lower medication bag to clear tubing and back-prime tubing; attach the appropriate label to the secondary tubing.
C) The correct steps of assembling the secondary infusion is as follows: Close the clamp on the secondary infusion tubing and spike the medication infusion bag; insert the secondary tubing needleless cannula into the distal primary tubing port located above the infusion pump; hang the secondary container above the level of the primary bag; lower medication bag to clear tubing and back-prime tubing; attach the appropriate label to the secondary tubing.

D) The correct steps of assembling the secondary infusion is as follows: Close the clamp on the secondary infusion tubing and spike the medication infusion bag; insert the secondary tubing needleless cannula into the distal primary tubing port located above the infusion pump; hang the secondary container above the level of the primary bag; lower medication bag to clear tubing and back-prime tubing; attach the appropriate label to the secondary tubing.
E) The correct steps of assembling the secondary infusion is as follows: Close the clamp on the secondary infusion tubing and spike the medication infusion bag; insert the secondary tubing needleless cannula into the distal primary tubing port located above the infusion pump; hang the secondary container above the level of the primary bag; lower medication bag to clear tubing and back-prime tubing; attach the appropriate label to the secondary tubing.
Page Ref: 179-180
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 2.8 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

19) A novice nurse instructs a client on the use of sublingual nitroglycerin. Which statement by the novice nurse requires intervention by the nurse preceptor?
A) "Be sure to take the medication prior to the start of your pain."
B) "Do not chew or swallow the tablet."
C) "The tablet may cause burning or tingling as it dissolves."
D) "Be sure to sit down when you decide to take the medication."
Answer: A
Explanation: A) Nitroglycerin is taken at the onset of the client's symptoms, not prior to.
B) A sublingual medication is not to be chewed or swallowed whole.
C) Nitroglycerin may cause burning or tingling as it dissolves.
D) The client should sit when taking the medication.
Page Ref: 155
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 2.5 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

20) A nurse mixes two insulins in one syringe for a client with diabetes. Which action by the nurse is incorrect?
A) Injecting a volume of air equal to the volume of medication to be withdrawn into the first vial.
B) Drawing up air in the syringe equal to the dose of both insulins.
C) Gently shaking the vials in order to ensure medication has dissolved.
D) Withdrawing the needle from the first vial and injecting the remaining air into the second vial.
Answer: C
Explanation: A) The volume of air equal to the volume of medication to be withdrawn should be injected into the first vial.
B) Air should be drawn up into the syringe equal to the dose of both insulins.
C) Shaking the insulins is not recommended because it will cause the medication to become frothy and difficult to measure. Instead, the nurse should gently roll the insulins in order to mix them.
D) The needle should be withdrawn from the first vial and the remaining air should be injected into the second vial.
Page Ref: 134-135
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 2.7 | QSEN Competencies: Evidence-Based Practice
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Quality & Safety

21) While giving the client a bath, the nurse notes the client has facial acne. What statement will the nurse omit when teaching the client about this condition?
A) "Use cool water when cleansing your face to close the pores."
B) "Wash your face frequently to remove oil and dirt."
C) "Avoid using oil-based creams on your face."
D) "Do not squeeze the lesions on your face."
Answer: A
Explanation: A) The nurse should instruct the client to use soap and warm water to cleanse the face.
B) The face should be washed frequently.
C) Oil-based creams should not be applied to the face.
D) Lesions should not be squeezed.
Page Ref: 102
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Intervention | Learning Outcome: 2.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Relationship Centered Care

22) The nurse is caring for an older adult client and performs a bed bath and linen change. Which action by the nurse poses an increase of injury in the client?
A) Washing the client with a washcloth.
B) Pulling linens underneath the client.
C) Assisting the client to turn in bed.
D) Covering the client with warm linens.
Answer: B
Explanation: A) The client should be washed with a washcloth.
B) The nurse should be most cautious when pulling linens underneath an older adult client. This increases the risk of skin impairment because some older adults can be more prone to injury of the skin.
C) The client should be assisted to turn in bed.
D) The client should be covered with warm linens.
Page Ref: 109
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 2.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

23) The nurse cares for a client who wears soft contact lenses for vision correction. Which statement will the nurse include when teaching the client about care of the lenses?
A) "If you do not have saline solution, saliva works to cleanse the lenses."
B) "If you wear disposable lenses, it is acceptable to cleanse them and wear them again."
C) "If you are removing the lens, place your thumb and forefinger directly on the lens."
D) "If you wear disposable lenses, be sure to cleanse the lens container daily."
Answer: C
Explanation: A) Saliva should not be used to cleanse the lenses.
B) Disposable lenses are not to be cleansed and reused.
C) When instructing the client to remove the soft lens, the nurse should tell the client to place the thumb and forefinger directly on the lens and squeeze gently.
D) A lens container is not used for disposable lenses.
Page Ref: 110
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Intervention | Learning Outcome: 2.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

24) The nurse prepares to perform a z-track injection to a client. Place the steps of the procedure in correct order.
A) Maintain displacement and insert needle at a 90-degree angle.
B) Inject medication slowly, keeping skin taut.
C) Pull skin 2.5–3.8 cm (1–1.5 in.) laterally away from the injection site.
D) Withdraw needle.
E) Release retracted skin.
Answer: C, A, B, D, E
Explanation: A) The injection technique of a z-track injection include the following steps: Pull skin 2.5–3.8 cm (1–1.5 in.) laterally away from the injection site; maintain displacement and insert needle at a 90-degree angle; inject medication slowly, keeping skin taut; withdraw the needle; release the retracted skin.
B) The injection technique of a z-track injection include the following steps: Pull skin 2.5–3.8 cm (1–1.5 in.) laterally away from the injection site; maintain displacement and insert needle at a 90-degree angle; inject medication slowly, keeping skin taut; withdraw the needle; release the retracted skin.
C) The injection technique of a z-track injection include the following steps: Pull skin 2.5–3.8 cm (1–1.5 in.) laterally away from the injection site; maintain displacement and insert needle at a 90-degree angle; inject medication slowly, keeping skin taut; withdraw the needle; release the retracted skin.
D) The injection technique of a z-track injection include the following steps: Pull skin 2.5–3.8 cm (1–1.5 in.) laterally away from the injection site; maintain displacement and insert needle at a 90-degree angle; inject medication slowly, keeping skin taut; withdraw the needle; release the retracted skin.

E) The injection technique of a z-track injection include the following steps: Pull skin 2.5–3.8 cm (1–1.5 in.) laterally away from the injection site; maintain displacement and insert needle at a 90-degree angle; inject medication slowly, keeping skin taut; withdraw the needle; release the retracted skin.
Page Ref: 171
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 2.4 | QSEN Competencies: Evidence-Based Practice
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

Clinical Nursing Skills: A Concept-Based Approach, 4e (Pearson)
Chapter 3 Comfort

1) The nurse cares for a neonate who appears in pain. The neonate has tight facial muscles, loud and shrill cry, rapid breathing, tense extremities and is thrashing about. Using the NIPS pain scale, which number will the nurse give the neonate?
A) 5
B) 6
C) 7
D) 8
Answer: C
Explanation: A) This is the incorrect use of NIPS.
B) This is the incorrect use of NIPS.
C) The Neonatal Infant Pain Scale (NIPS) is a standardized pain scale used for assessing pain in neonates up to 6 weeks of age. The scale is based on facial expressions, cry, breathing patterns, arm and leg movements, and state of arousal. Tight facial muscles (1 point), loud and shrill cry (2 points), rapid breathing (1 point), tense extremities (2 points), and increased movement (1 point) equal 7 points.
D) This is the incorrect use of NIPS.
Page Ref: 192
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 2.3 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Relationship Centered Care

2) The nurse sets up a PCA pump for a postoperative client. Which safety parameters will the nurse use? **Select all that apply.**

A) Dose volume limits
B) Partial dose settings
C) Dosage limits
D) Lockout interval
E) Re-programming alarm settings

Answer: A, C, D

Explanation: A) Dose volume limit parameters limit the amount of drug that the client can receive when the client pushes the control button. This is an important safety parameter the nurse will use.

B) There are no partial dose settings on a PCA pump.

C) Dosage limits set the dosage limits as specified on the order. This is an important safety parameter the nurse will use.

D) The lockout interval is set in order to ensure that doses are not administered too frequently. This is an important safety parameter the nurse will use.

E) Alarm settings should not be re-programmed.

Page Ref: 204-205
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 3.5 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

3) The nurse cares for a client who requires a PCA for pain control. The healthcare provider has ordered a loading dose for the client. Place the steps in order for the nurse to provide the loading dose by PCA pump.
A) Set the safety parameters.
B) Press the loading dose control button.
C) Set the volume to be delivered.
D) Set the pump for a lockout time of zero minutes.
Answer: D, C, B, A
Explanation: A) When providing the loading dose by PCA pump, the nurse must first set the pump for a lockout time of zero minutes. Next, the nurse will set the volume to be delivered and press the loading dose control button. Finally, the nurse will set the safety parameters.
B) When providing the loading dose by PCA pump, the nurse must first set the pump for a lockout time of zero minutes. Next, the nurse will set the volume to be delivered and press the loading dose control button. Finally, the nurse will set the safety parameters.
C) When providing the loading dose by PCA pump, the nurse must first set the pump for a lockout time of zero minutes. Next, the nurse will set the volume to be delivered and press the loading dose control button. Finally, the nurse will set the safety parameters.
D) When providing the loading dose by PCA pump, the nurse must first set the pump for a lockout time of zero minutes. Next, the nurse will set the volume to be delivered and press the loading dose control button. Finally, the nurse will set the safety parameters.
Page Ref: 204
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 3.5 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

4) The nurse is caring for a client in acute pain. When assessing the client's quality of pain, which statement will the nurse use?
A) "How long have you been having pain?"
B) "Is the pain better or worse at certain times of the day or night?"
C) "What words would you use to describe your pain?"
D) "Have you noticed any time during the day or night that the pain is better or worse?"
Answer: C
Explanation: A) Asking how long the pain has been present assesses duration.
B) Asking if the pain changes during the day assesses recurrence.
C) Quality of pain may be assessed by asking the client, "What words would you use to describe your pain?"
D) Asking if the pain is different during the day assesses for recurrence.
Page Ref: 194
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Assessment | Learning Outcome: 3.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Relationship Centered Care

5) A nurse assesses a client who is experiencing acute pain. Which aspects of the pain assessment are gathered first before the detailed assessment? **Select all that apply**.
A) Location
B) Provocation
C) Intensity
D) Quality
E) Radiation
Answer: A, C, D
Explanation: A) For clients experiencing acute or severe pain, the nurse may focus on determining location, intensity, and quality–and quickly follow with an intervention. Clients with less severe or chronic pain can usually provide a more detailed description, and the nurse can obtain a comprehensive pain assessment.
B) Precipitating factors can be assessed during the detailed assessment.
C) For clients experiencing acute or severe pain, the nurse may focus on determining location, intensity, and quality–and quickly follow with an intervention. Clients with less severe or chronic pain can usually provide a more detailed description, and the nurse can obtain a comprehensive pain assessment.
D) For clients experiencing acute or severe pain, the nurse may focus on determining location, intensity, and quality–and quickly follow with an intervention. Clients with less severe or chronic pain can usually provide a more detailed description, and the nurse can obtain a comprehensive pain assessment.
E) Radiation would be assessed during the detailed assessment.
Page Ref: 194

Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Intervention | Learning Outcome: 3.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Relationship Centered Care

6) The nurse is caring for a client who is using a TENS unit for pain management. Which statements will the nurse use when teaching the client about this therapy? **Select all that apply**.
A) "Make sure and cover the unit while showering or bathing."
B) "When turning the unit on, make sure the amplitude control is set to 5."
C) "With the unit off, plug the lead wires into the battery-operated unit at one end, leaving the electrodes at the other end."
D) "Increase the amplitude until you feel discomfort and then decrease the amplitude until you feel comfortable."
E) "Wash, rinse, and dry the area where you would like to apply the electrodes."
Answer: C, D, E
Explanation: A) The TENS unit is not to be used in the shower or bathing.
B) The amplitude control should be set at level 0.
C) The nurse should instruct the client that, with the TENS unit off, plug the lead wires into the battery-operated unit at one end, leaving electrodes at the other end.
D) The client should be instructed to slowly increase the intensity of the stimulus (amplitude) until a slight increase in discomfort is noted.
E) The area should be washed, rinsed, and dried before applying the electrodes.
Page Ref: 201
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Intervention | Learning Outcome: 3.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Relationship Centered Care

7) The nurse cares for a client who wants to try biofeedback for relief of chronic pain. What advantages to this therapy does the nurse recognize? **Select all that apply**.
A) Increases circulation and endorphins
B) Completely controlled by the client
C) Rapid pain relief
D) Redirects energy flow through pressure on meridian points
E) Promotes stress reduction as well as pain relief
Answer: B, E
Explanation: A) Massage increases circulation and endorphins.
B) Biofeedback is an electric monitoring device that feeds back effect of behavior so the client can control internal processes (such as the heart rate). Advantages to biofeedback include the fact that it is completely controlled by the client.
C) Ice therapy promotes rapid pain relief.
D) Acupressure redirects energy flow through pressure on meridian points.
E) Advantages to biofeedback include the fact that it promotes stress reduction as well as pain relief.
Page Ref: 203
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Assessment | Learning Outcome: 3.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 1.3 Demonstrate clinical judgment founded on a broad knowledge base.
NLN Competencies: Knowledge and Science

8) The nurse cares for a client with chronic pain who asks the nurse about using acupressure for pain relief. Which statements will the nurse include in the teaching regarding how this treatment works for pain relief? **Select all that apply**.
A) "The pressure compresses and splints irritated nerve endings."
B) "It redirects energy flow through pressure on meridian points."
C) "The therapy restores structural integrity and balance."
D) "The therapy reduces pain and increases endorphins."
E) "It manipulates muscles and realigns spinal column nerve function."
Answer: B, D
Explanation: A) Acupressure does not compress nerve endings.
B) Acupressure is a therapy based on the traditional Chinese method of acupuncture. This method involves using specific points located on meridians at various places on the body.
C) Chiropractic care restores structural integrity and balance.
D) This therapy reduces pain and increases endorphins.
E) Chiropractic care manipulates muscles and realigns spinal column nerve function.
Page Ref: 203
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Intervention | Learning Outcome: 3.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 1.3 Demonstrate clinical judgment founded on a broad knowledge base.
NLN Competencies: Knowledge and Science

9) The nurse prepares to apply dry heat to a client's extremity in an effort to reduce pain. Which variables are recognized by the nurse to affect physiological tolerance to heat and cold? **Select all that apply.**

A) Body part location
B) Size of the exposed body part
C) Individual tolerance
D) Intactness of skin
E) Gender

Answer: A, B, C, D

Explanation: A) Body part location affects the physiological tolerance to heat and cold. For example, the back of the hand and foot are not very temperature sensitive. In contrast, the inner aspect of the wrist and forearm, the neck, and the perineal area are temperature sensitive.
B) The size of the exposed body part affects the physiological tolerance to heat and cold. The larger the area exposed to heat and cold is, the lower is the tolerance.
C) Individual tolerance affects the physiological tolerance to heat and cold. The very young and the very old have the least physiological tolerance.
D) Injured areas of the skin are more susceptible to temperature variations versus intact skin.
E) Gender does not affect tolerance to heat or cold application.

Page Ref: 207
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Assessment | Learning Outcome: 3.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 1.3 Demonstrate clinical judgment founded on a broad knowledge base.
NLN Competencies: Knowledge and Science

10) The nurse is caring for five clients with acute pain. When considering the use of heat and cold therapy, which medical conditions will the nurse determine require special precautions? **Select all that apply.**
A) Diabetes
B) Venous insufficiency
C) Asthma
D) Congestive heart failure
E) Arterial disease
Answer: A, B, D, E
Explanation: A) Clients with diabetes require special precautions during heat and cold therapy because these clients lack the normal ability to dissipate heat via the blood circulation, which puts them at risk for tissue damage with heat applications. Cold applications are contraindicated for these clients.
B) Clients with peripheral vascular disease (peripheral arterial disease and venous insufficiency) require special precautions during heat and cold therapy because these clients lack the normal ability to dissipate heat via the blood circulation, which puts them at risk for tissue damage with heat applications. Cold applications are contraindicated for these clients.
C) Clients with asthma do not require special precautions.
D) Clients with congestive heart failure and those with diabetes require special precautions during heat and cold therapy because these clients lack the normal ability to dissipate heat via the blood circulation, which puts them at risk for tissue damage with heat applications. Cold applications are contraindicated for these clients.
E) Clients with peripheral vascular disease (peripheral arterial disease and venous insufficiency) require special precautions during heat and cold therapy because these clients lack the normal ability to dissipate heat via the blood circulation, which puts them at risk for tissue damage with heat applications. Cold applications are contraindicated for these clients.

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Page Ref: 208
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Assessment | Learning Outcome: 3.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 1.3 Demonstrate clinical judgment founded on a broad knowledge base.
NLN Competencies: Knowledge and Science

11) A nurse cares for a 13-year-old adolescent with a terminal illness. Which client statement does the nurse expect to hear from this client regarding death and dying?
A) "I will go to sleep for a long time and then wake up."
B) "I know that people die with my disease but I won't die."
C) "I wonder what happens to people after death."
D) "I know people die but I will defy my own death."
Answer: D
Explanation: A) Children up to age 5 believe death is being asleep.
B) Children ages 5 to 9 years believe own death can be avoided.
C) Children ages 9 to 12 years express an interest in the afterlife.
D) An adolescent client fears a lingering death, often fantasizing that death may be defied by acting in reckless behavior (e.g., substance abuse, dangerous driving).
Page Ref: 223
Cognitive Level: Analyzing
Client Need/Sub: Psychosocial Integrity
Standards: Nursing Process: Assessment | Learning Outcome: 3.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Relationship Centered Care

12) The nurse cares for a client who needs a PCA pump for control of postoperative pain. Which task can the nurse delegate to the unlicensed assistive personnel (UAP)?
A) Pushing the client button if the client is unable.
B) Silencing the pump alarm while waiting for the nurse.
C) Reporting specific client observations.
D) Asking the client about level of pain.
Answer: C
Explanation: A) Pushing the client's PCA button is administering an intravenous medication and is a task for the nurse only.
B) The UAP should not silence the PCA pump.
C) The nurse may delegate the UAP to report specific client observations (such as reporting inadequate pain control).
D) The UAP should not determine the client's pain level because it involves assessment of the client's clinical situation and assessment should not be performed by unlicensed personnel.
Page Ref: 204
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: Nursing Process: Intervention | Learning Outcome: 3.5 | QSEN Competencies: Teamwork and Collaboration
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Teamwork

13) The nurse cares for an older adult client who will have heat and cold therapy to assist with pain. Which lifespan considerations does the nurse consider when using this treatment for the client? **Select all that apply**.
A) Skin cells proliferate quicker as one ages.
B) Sensitivity to pain decreases as one ages.
C) Skin becomes thinner as one ages.
D) Moisture in the skin decreases as one ages.
E) Skin burns easier as one ages.
Answer: B, C, D, E
Explanation: A) Skin cells do not proliferate quicker with aging.
B) Older adults have a reduced sensitivity to pain, and therefore may not feel untoward effects of heat and cold treatment.
C) Older adults have thinner skin.
D) Temperature should be reduced when using heat therapy because older adult patient's skin burns more easily.
E) Because skin is thinner, skin burns easier as one ages.
Page Ref: 218
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 3.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

14) The nurse is caring for a client with acute pain and uses the FLACC pain assessment. Which clinical scenario does the nurse recognize as LEAST appropriate for use of the FLACC pain assessment?
A) Situations where clients self-report pain.
B) Situations requiring rapid pain assessment.
C) Clients who are asleep.
D) Clients who are children.
Answer: B
Explanation: A) The FLACC pain assessment is not used for clients who can self-report pain.
B) The FLACC pain assessment requires observation of the client for at least 5 minutes before a determination regarding the pain can be made.
C) It is used for clients who are asleep.
D) It is used for children.
Page Ref: 192
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 3.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Relationship Centered Care

15) The nurse is preparing to use a disposable hot pack on the client for pain relief. Which action will the nurse prioritize as an appropriate task for the UAP?
A) Observing the site of application and reporting abnormal findings.
B) Assessing the client's level of pain.
C) Determining if the client requires additional therapy.
D) Documenting the client's response to therapy.
Answer: A
Explanation: A) The UAP may observe the site of the application and report abnormal findings.
B) The nurse assesses the level of pain.
C) The nurse determines if the client needs additional therapy.
D) The nurse documents the client's response to therapy.
Page Ref: 212
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Management of Care
Standards: Nursing Process: Intervention | Learning Outcome: 3.4 | QSEN Competencies: Teamwork and Collaboration
AACN Domains and Comps.: 6.4 Work with other professions to maintain a climate of mutual learning, respect, and shared values.
NLN Competencies: Teamwork

16) The nurse assesses a toddler for pain using the FLACC scale. The nurse notes the client is crying steadily with a quivering chin, is kicking, is shifting back and forth, and is difficult to console. What number does the nurse document for the client's pain, based on the FLACC scale?
A) 8

B) 9
C) 10
D) 11
Answer: B
Explanation: A) The assessment tool was not used correctly.
B) The FLACC behavioral pain assessment may be used to help the nurse determine the client's level of pain. Assessment is based on findings of the face, legs, activity, cry, and consolability. A steady cry (2) with quivering chin (2), kicking (2), shifting back and forth (1), and difficult to console (2) results in a FLACC score of 9.
C) The assessment tool was not used correctly.
D) The maximum score on the FLACC tool is 10.
Page Ref: 192
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 3.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Relationship Centered Care

17) The nurse is caring for a client in acute pain and plans to use a pain scale tool for assessment. What is the major advantage in using this tool?
A) It allows organization in the assessment process.
B) It works with the same efficacy among the entire population.
C) It allows for variation among various cultures.
D) It can always be performed quickly.
Answer: A
Explanation: A) The major advantage of a standardized pain scale tool for assessment of the client's pain is that it allows the nurse to stay organized in the assessment process.
B) While efficient in assessing a client's pain, the tool does not factor in cultural variances and perceptions of pain.
C) Pain scales do not factor in cultural variances.
D) The idea that most tools may be performed quickly is not universally true.
Page Ref: 195
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 3.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Relationship Centered Care

18) The nurse is caring for a client who is dying. When prioritizing care, which intervention will the nurse provide to meet the client's physiological needs?
A) Encourage frequent ambulation and deep breathing.

B) Initiate total nutrition intravenously.
C) Administer curative medications.
D) Encourage favorite foods as tolerated.
Answer: D
Explanation: A) The client's tolerance should be supported. The client may not have the strength to ambulate or take deep breaths.
B) Intravenous nutrition is determined according to the client's preference.
C) Curative medications are not prescribed for a client who is dying.
D) Encouraging favorite foods as tolerated is an important nursing intervention the nurse will perform for the dying client.
Page Ref: 220
Cognitive Level: Applying
Client Need/Sub: Psychosocial Integrity
Standards: Nursing Process: Intervention | Learning Outcome: 3.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.1 Engage with the individual in establishing a caring relationship.
NLN Competencies: Relationship Centered Care

19) The nurse prepares to perform a pain assessment and chooses to use a standardized pain assessment tool. Place the steps in order for the use of the standardized pain assessment tool.
A) Assess the client's physiological response to pain.
B) Assess the client's perception of pain.
C) Perform a focused assessment.
D) Document the findings.
Answer: B, A, C, D
Explanation: A) The steps to performing a pain assessment using a standardized pain assessment tool is as follows: Assess the client's perception of pain (including location, intensity, and quality), assess the client's physiological response to pain (i.e., changes in vital signs), perform a focused assessment, and document the findings.
B) The steps to performing a pain assessment using a standardized pain assessment tool is as follows: Assess the client's perception of pain (including location, intensity, and quality), assess the client's physiological response to pain (i.e., changes in vital signs), perform a focused assessment, and document the findings.
C) The steps to performing a pain assessment using a standardized pain assessment tool is as follows: Assess the client's perception of pain (including location, intensity, and quality), assess the client's physiological response to pain (i.e., changes in vital signs), perform a focused assessment, and document the findings.
D) The steps to performing a pain assessment using a standardized pain assessment tool is as follows: Assess the client's perception of pain (including location, intensity, and quality), assess the client's physiological response to pain (i.e., changes in vital signs), perform a focused assessment, and document the findings.
Page Ref: 194

Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 3.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Relationship Centered Care

20) The nurse prepares to apply a TENS unit on a client who is experiencing pain. Place the steps of this procedure in the correct order.
A) With the unit off, plug the lead wires into the unit.
B) Insert the battery and test for functioning.
C) Turn the unit on and ensure the amplitude is set to zero.
D) Apply the electrodes to the client.
E) Increase the amplitude until the client notes discomfort.
F) Slowly decrease the amplitude until the client notes a pleasant sensation.
Answer: B, A, D, C, E, F
Explanation: A) Application of the TENS unit is as follows: Insert the battery and test for functioning; with the unit off, plug the lead wires into the unit; apply the electrodes to the client; turn the unit on and ensure the amplitude is set to zero; increase the amplitude until the client notes discomfort; slowly decrease the amplitude until the client notes a pleasant sensation.
B) Application of the TENS unit is as follows: Insert the battery and test for functioning; with the unit off, plug the lead wires into the unit; apply the electrodes to the client; turn the unit on and ensure the amplitude is set to zero; increase the amplitude until the client notes discomfort; slowly decrease the amplitude until the client notes a pleasant sensation.
C) Application of the TENS unit is as follows: Insert the battery and test for functioning; with the unit off, plug the lead wires into the unit; apply the electrodes to the client; turn the unit on and ensure the amplitude is set to zero; increase the amplitude until the client notes discomfort; slowly decrease the amplitude until the client notes a pleasant sensation.
D) Application of the TENS unit is as follows: Insert the battery and test for functioning; with the unit off, plug the lead wires into the unit; apply the electrodes to the client; turn the unit on and ensure the amplitude is set to zero; increase the amplitude until the client notes discomfort; slowly decrease the amplitude until the client notes a pleasant sensation.

E) Application of the TENS unit is as follows: Insert the battery and test for functioning; with the unit off, plug the lead wires into the unit; apply the electrodes to the client; turn the unit on and ensure the amplitude is set to zero; increase the amplitude until the client notes discomfort; slowly decrease the amplitude until the client notes a pleasant sensation.
F) Application of the TENS unit is as follows: Insert the battery and test for functioning; with the unit off, plug the lead wires into the unit; apply the electrodes to the client; turn the unit on and ensure the amplitude is set to zero; increase the amplitude until the client notes discomfort; slowly decrease the amplitude until the client notes a pleasant sensation.
Page Ref: 201
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Intervention | Learning Outcome: 3.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Relationship Centered Care

Clinical Nursing Skills: A Concept-Based Approach, 4e **(Pearson)**
Chapter 4 Elimination

1) The nurse prepares to obtain a urine sample from a client's closed drainage system. Place the procedure steps in the correct order.
A) Disinfect the needle insertion site.
B) Insert the needle at a 30-to 40-degree angle.
C) Unclamp the catheter.
D) Transfer the urine to the specimen container.
E) Withdraw the required amount of urine.
F) Clamp the drainage tubing at least 8 cm (3 in.) below the sampling port for 30 minutes.
Answer: F, A, B, E, C, D
Explanation: A) The procedure for obtaining a urine sample from a closed drainage system is as follows: clamp the drainage tubing at least 8 cm (3 in.) below the sampling port for 30 minutes; disinfect the needle insertion site; insert the needle at a 30- to 40-degree angle; withdraw the required amount of urine; unclamp the catheter; transfer the urine to the specimen container.
B) The procedure for obtaining a urine sample from a closed drainage system is as follows: clamp the drainage tubing at least 8 cm (3 in.) below the sampling port for 30 minutes; disinfect the needle insertion site; insert the needle at a 30- to 40-degree angle; withdraw the required amount of urine; unclamp the catheter; transfer the urine to the specimen container.
C) The procedure for obtaining a urine sample from a closed drainage system is as follows: clamp the drainage tubing at least 8 cm (3 in.) below the sampling port for 30 minutes; disinfect the needle insertion site; insert the needle at a 30- to 40-degree angle; withdraw the required amount of urine; unclamp the catheter; transfer the urine to the specimen container.

D) The procedure for obtaining a urine sample from a closed drainage system is as follows: clamp the drainage tubing at least 8 cm (3 in.) below the sampling port for 30 minutes; disinfect the needle insertion site; insert the needle at a 30- to 40-degree angle; withdraw the required amount of urine; unclamp the catheter; transfer the urine to the specimen container.
E) The procedure for obtaining a urine sample from a closed drainage system is as follows: clamp the drainage tubing at least 8 cm (3 in.) below the sampling port for 30 minutes; disinfect the needle insertion site; insert the needle at a 30- to 40-degree angle; withdraw the required amount of urine; unclamp the catheter; transfer the urine to the specimen container.
F) The procedure for obtaining a urine sample from a closed drainage system is as follows: clamp the drainage tubing at least 8 cm (3 in.) below the sampling port for 30 minutes; disinfect the needle insertion site; insert the needle at a 30- to 40-degree angle; withdraw the required amount of urine; unclamp the catheter; transfer the urine to the specimen container.
Page Ref: 234
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 4.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

2) The nurse prepares to obtain a urine specimen from a client's indwelling catheter. What is the nurse's understanding of the purpose of clamping the indwelling catheter prior to collection of urine?
A) Decreases client discomfort
B) Increases urine production
C) Promotes sterile collection
D) Eases technique of procedure
Answer: C
Explanation: A) Clamping is not done to decrease the client's discomfort.
B) Clamping is not done to increase urine production.
C) Clamping the client's indwelling catheter promotes the sterile collection of urine because sterile urine collects in the tube, allowing for sterile collection.
D) Clamping is not done to ease technique of the procedure.
Page Ref: 247
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 4.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

3) A nurse prepares to administer a warm water enema to a client. Place the steps of the procedure in correct order.
A) Raise the solution container.
B) Open the clamp.
C) Encourage the client to retain the solution.
D) Lift the upper buttock, insert the tube slowly.
E) Assist the client to the left lateral position with right leg flexed.
F) Allow the solution to run through the tubing to remove air.
Answer: F, E, D, A, B, C
Explanation: A) The steps of the warm water enema administration is as follows: Allow the solution to run through the tubing to remove air; assist the client to the left lateral position with the right leg flexed; lift the upper buttock and insert the tube slowly; raise the solution container and open the clamp; encourage the client to retain the solution.
B) The steps of the warm water enema administration is as follows: Allow the solution to run through the tubing to remove air; assist the client to the left lateral position with the right leg flexed; lift the upper buttock and insert the tube slowly; raise the solution container and open the clamp; encourage the client to retain the solution.
C) The steps of the warm water enema administration is as follows: Allow the solution to run through the tubing to remove air; assist the client to the left lateral position with the right leg flexed; lift the upper buttock and insert the tube slowly; raise the solution container and open the clamp; encourage the client to retain the solution.
D) The steps of the warm water enema administration is as follows: Allow the solution to run through the tubing to remove air; assist the client to the left lateral position with the right leg flexed; lift the upper buttock and insert the tube slowly; raise the solution container and open the clamp; encourage the client to retain the solution.

E) The steps of the warm water enema administration is as follows: Allow the solution to run through the tubing to remove air; assist the client to the left lateral position with the right leg flexed; lift the upper buttock and insert the tube slowly; raise the solution container and open the clamp; encourage the client to retain the solution.
F) The steps of the warm water enema administration is as follows: Allow the solution to run through the tubing to remove air; assist the client to the left lateral position with the right leg flexed; lift the upper buttock and insert the tube slowly; raise the solution container and open the clamp; encourage the client to retain the solution.
Page Ref: 269
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 4.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Relationship Centered Care

4) The registered nurse acts as preceptor to a novice nurse who is placing an indwelling urinary catheter for a client. Which action by the novice nurse requires intervention by the preceptor?
A) Removing and discarding clean gloves after opening the drainage package.
B) Cleansing the urethral meatus before removing the catheter from the protective sleeve.
C) Donning sterile gloves prior to attaching the catheter to the drainage system.
D) Lubricating the tip of the catheter before inserting the tip of the prefilled syringe into the catheter side arm.
Answer: B
Explanation: A) Clean gloves should be removed and discarded after opening the drainage package.
B) The nurse should remove the catheter from the protective sleeve prior to cleansing the urethral meatus. This action will require intervention by the nurse preceptor.
C) Sterile gloves should be applied before attaching the catheter to the drainage system.
D) The tip of the catheter should be lubricated before inserting the tip of the prefilled syringe into the catheter side arm.
Page Ref: 250
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 4.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

5) When placing the client on a bedpan, which position will the nurse place the client?

A) High-Fowler
B) Semi-Fowler
C) Upright
D) Supine
Answer: B
Explanation: A) The high-Fowler position is not the best to use for a bedpan.
B) The semi-Fowler position alleviates back strain and permits a more normal position for elimination.
C) The upright position is not the best to use for a bedpan.
D) The supine position is not the best to use for a bedpan.
Page Ref: 240
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Intervention | Learning Outcome: 4.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Relationship Centered Care

6) The nurse attempts to obtain a urine sample from a client's ileal conduit. After correct sterile catheterization, no urine output is noted. Which action should the nurse take?
A) Contact the healthcare provider.
B) Reinsert the catheter.
C) Ask the client to drink water.
D) Advance the catheter further in the stoma.
Answer: C
Explanation: A) The healthcare provider does not need to be contacted.
B) The catheter does not need to be reinserted.
C) After correct sterile catheterization of an ileal conduit, if no urine is obtained, the nurse should ask the client to drink water in order to produce urine.
D) The catheter does not need to be advanced further into the stoma.
Page Ref: 235
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 4.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Relationship Centered Care

7) When auscultating a client's AV fistula, the nurse notes a whooshing sound. What term is used to describe this finding?
A) Bruit
B) Murmur
C) Gallop
D) Click
Answer: A
Explanation: A) The whooshing sound heard on auscultation of a patent AV fistula is called bruit.
B) Murmur is used to describe an abnormal heart sound.
C) Gallop is used to describe an abnormal heart sound.
D) Click is used to describe an abnormal heart sound.
Page Ref: 286
Cognitive Level: Remembering
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 4.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Relationship Centered Care

8) An uncircumcised male client needs to provide a clean-catch urine sample. Which client teaching will the nurse provide the client regarding the procedure? **Select all that apply**.

A) Retract the foreskin slightly.
B) Pull the foreskin over the meatus.
C) Use a circular motion to clean the meatus.
D) Use each towelette only once, then discard.
E) Void a small amount prior to collecting the sample.

Answer: A, C, D, E

Explanation: A) When instructing the uncircumcised male on the proper technique of a clean-catch urine sample, the nurse will instruct the client to retract the foreskin slightly.
B) Pulling the foreskin over the meatus is not correct and the nurse will not instruct the client to do this.
C) When instructing the uncircumcised male on the proper technique of a clean-catch urine sample, the nurse will instruct the client to use a circular motion to clean the meatus.
D) When instructing the uncircumcised male on the proper technique of a clean-catch urine sample, the nurse will instruct the client to use each towelette only once.
E) When instructing the uncircumcised male on the proper technique of a clean-catch urine sample, the nurse will instruct the client to void a small amount prior to collecting the sample.

Page Ref: 233
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 4.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Relationship Centered Care

9) When assessing the client's AV fistula, the nurse notes vibration at the fistula site. How should the nurse respond to this finding?

A) Contact the healthcare provider.
B) Ask the client how long this has occurred.
C) Determine when the fistula was placed.
D) Document the finding.

Answer: D

Explanation: A) The healthcare provider does not need to be contacted.
B) The client does not need to be asked about the vibration.
C) The nurse does not need to determine when the fistula was first created.
D) Vibration of the AV fistula is known as "thrill" and is a normal finding of the AV fistula. The nurse should document the finding.

Page Ref: 286
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Assessment | Learning Outcome: 3.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Relationship Centered Care

10) The nurse performs a sterile urine specimen collection from an ileal conduit. Which action by the nurse is incorrect and may lead to inaccurate results?
A) Removing the collection pouch prior to obtaining the sample.
B) Inserting the tip of the catheter into the stoma approximately 4 cm (1.5 inches).
C) Obtaining the sample from the collection pouch.
D) Placing towels around the stoma.
Answer: C
Explanation: A) The collection pouch should be removed.
B) The catheter should be inserted into the stoma.
C) The nurse should not use the collection pouch to obtain the urine sample because this may contain bacteria and is not an accurate representation of a sterile urine specimen.
D) Towels should be placed around the stoma.
Page Ref: 235
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 4.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

11) The home care nurse prepares to drain the fluid of a client with continuous ambulatory peritoneal dialysis (CAPD). Place the steps in correct order for the procedure to drain the fluid.
A) Attach the sterile bag and transfer set to the catheter.
B) Place the bag on a low stool or table below the client's abdomen.
C) Unclamp the tubing and allow fluid to drain.
D) Reclamp the tubing.
E) Don gloves and uncap the catheter.
Answer: E, A, B, C, D
Explanation: A) The correct procedure to drain the peritoneal fluid of a client with CAPD is as follows: Don gloves and uncap the catheter, maintaining surgical asepsis; attach the sterile bag and transfer set to the catheter; place the bag on a low stool or table below the client's abdomen; unclamp the tubing and allow fluid to drain; reclamp the tubing.
B) The correct procedure to drain the peritoneal fluid of a client with CAPD is as follows: Don gloves and uncap the catheter, maintaining surgical asepsis; attach the sterile bag and transfer set to the catheter; place the bag on a low stool or table below the client's abdomen; unclamp the tubing and allow fluid to drain; reclamp the tubing.
C) The correct procedure to drain the peritoneal fluid of a client with CAPD is as follows: Don gloves and uncap the catheter, maintaining surgical asepsis; attach the sterile bag and transfer set to the catheter; place the bag on a low stool or table below the client's abdomen; unclamp the tubing and allow fluid to drain; reclamp the tubing.
D) The correct procedure to drain the peritoneal fluid of a client with CAPD is as follows: Don gloves and uncap the catheter, maintaining surgical asepsis; attach the sterile bag and transfer set to the catheter; place the bag on a low stool or table below the client's abdomen; unclamp the tubing and allow fluid to drain; reclamp the tubing.

E) The correct procedure to drain the peritoneal fluid of a client with CAPD is as follows: Don gloves and uncap the catheter, maintaining surgical asepsis; attach the sterile bag and transfer set to the catheter; place the bag on a low stool or table below the client's abdomen; unclamp the tubing and allow fluid to drain; reclamp the tubing.
Page Ref: 281
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 4.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

12) The nurse prepares to remove a client's indwelling urinary catheter. Which technique will the nurse use when performing this procedure? **Select all that apply**.
A) Aspirate the balloon vigorously.
B) Withdraw all the fluid from the balloon.
C) Detach the catheter from the client's skin.
D) Use clean gloves instead of sterile gloves.
E) Place a towel between the client's legs.
Answer: B, C, D, E
Explanation: A) Aspirating the balloon vigorously may collapse the inflation lumen and prevent balloon deflation.
B) When removing the client's indwelling urinary catheter, the nurse will withdraw all the fluid from the balloon.
C) When removing the client's indwelling urinary catheter, the nurse will detach the catheter from the client's skin.
D) The procedure should be performed using clean gloves instead of sterile gloves.
E) A towel should be placed between the client's legs.
Page Ref: 246-247
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 4.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

13) The nurse prepares to perform an indwelling urinary catheterization for a client who will undergo surgery. Place the steps of client positioning and sterile glove donning in the correct order.
A) Open the drainage package, maintaining sterility.
B) Position the client.
C) Remove and discard gloves; perform hand hygiene.
D) Open the catheterization kit; apply sterile gloves.
Answer: B, A, C, D
Explanation: A) The pre-procedure steps of indwelling urinary catheterization includes: Positioning the client; opening the drainage package, ensuring sterility; removing and discarding gloves, performing hand hygiene; opening the catheterization kit and applying sterile gloves.
B) The pre-procedure steps of indwelling urinary catheterization includes: Positioning the client; opening the drainage package, ensuring sterility; removing and discarding gloves, performing hand hygiene; opening the catheterization kit and applying sterile gloves.
C) The pre-procedure steps of indwelling urinary catheterization includes: Positioning the client; opening the drainage package, ensuring sterility; removing and discarding gloves, performing hand hygiene; opening the catheterization kit and applying sterile gloves.
D) The pre-procedure steps of indwelling urinary catheterization includes: Positioning the client; opening the drainage package, ensuring sterility; removing and discarding gloves, performing hand hygiene; opening the catheterization kit and applying sterile gloves.
Page Ref: 249
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 4.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

14) The nurse cares for a client who requires hemodialysis and has an arteriovenous fistula. Which statements will the nurse include when teaching the client safety precautions for the AV fistula? **Select all that apply**.

A) "Keep the AV fistula dry and avoid washing with soap."
B) "Do not wear constrictive clothing or jewelry."
C) "Avoid lifting heavy objects with the extremity that has the AV fistula."
D) "Avoid lying on the extremity with the AV fistula."
E) "Immediately report swelling or discoloration."

Answer: B, C, D, E

Explanation: A) The AV fistula can be cleansed with soap and water.

B) Safety precautions for the AV fistula include avoiding constrictive clothing or jewelry.

C) Safety precautions for the AV fistula include avoiding heavy lifting with the extremity with the AV fistula.

D) Safety precautions for the AV fistula include avoiding lying on the extremity with the AV fistula.

E) Safety precautions for the AV fistula include immediately reporting swelling or discoloration of the extremity with the AV fistula.

Page Ref: 286
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Intervention | Learning Outcome: 4.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Relationship Centered Care

15) The home care nurse cares for a client who requires continuous ambulatory peritoneal dialysis (CAPD) at home. Place the steps in the correct order for infusing the dialysate.
A) Warm the dialysate.
B) Add medications to the dialysate as ordered.
C) Connect tubing to dialysate bag.
D) Perform hand hygiene and don gloves.
E) Hang the dialysate bag above the client's shoulder and open the clamp.
Answer: A, D, B, C, E
Explanation: A) Infusion of the dialysate using CAPD is a sterile technique with steps as follows: Warm the dialysate; perform hand hygiene for 3 minutes using antibacterial soap, then don gloves; add medications to the dialysate as ordered, using sterile technique; connect the tubing to the dialysate bag; hang the dialysate bag above the client's shoulder and open the clamp.
B) Infusion of the dialysate using CAPD is a sterile technique with steps as follows: Warm the dialysate; perform hand hygiene for 3 minutes using antibacterial soap, then don gloves; add medications to the dialysate as ordered, using sterile technique; connect the tubing to the dialysate bag; hang the dialysate bag above the client's shoulder and open the clamp.
C) Infusion of the dialysate using CAPD is a sterile technique with steps as follows: Warm the dialysate; perform hand hygiene for 3 minutes using antibacterial soap, then don gloves; add medications to the dialysate as ordered, using sterile technique; connect the tubing to the dialysate bag; hang the dialysate bag above the client's shoulder and open the clamp.
D) Infusion of the dialysate using CAPD is a sterile technique with steps as follows: Warm the dialysate; perform hand hygiene for 3 minutes using antibacterial soap, then don gloves; add medications to the dialysate as ordered, using sterile technique; connect the tubing to the dialysate bag; hang the dialysate bag above the client's shoulder and open the clamp.

E) Infusion of the dialysate using CAPD is a sterile technique with steps as follows: Warm the dialysate; perform hand hygiene for 3 minutes using antibacterial soap, then don gloves; add medications to the dialysate as ordered, using sterile technique; connect the tubing to the dialysate bag; hang the dialysate bag above the client's shoulder and open the clamp.
Page Ref: 281-282
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 4.5 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

16) The nurse is planning care for a client who receives peritoneal dialysis. Which problem will the nurse determine is PRIORITY?
A) Nutrition
B) Risk for infection
C) Fatigue
D) Nausea
Answer: B
Explanation: A) Nutrition is not a priority for the client receiving peritoneal dialysis.
B) The client who receives peritoneal dialysis is at increased risk for infection, which can be serious or evenly deadly to the client. This is the priority for nursing care.
C) Fatigue is not a priority for the client receiving peritoneal dialysis.
D) Nausea is not a priority for the client receiving peritoneal dialysis.
Page Ref: 227
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Planning | Learning Outcome: 4.5 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

17) The nurse cares for a client with an AV fistula for hemodialysis. Which assessments will the nurse perform when assessing the AV fistula? **Select all that apply**.
A) Palpation
B) Auscultation
C) Inspection
D) Percussion
Answer: A, B, C
Explanation: A) The fistula should be palpated for a thrill or vibration.
B) The fistula should be auscultated for a bruit.
C) The site should be inspected for signs of infection.
D) Percussion is not indicated when assessing the AV fistula.
Page Ref: 286
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 4.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Relationship Centered Care

18) The nurse teaches a client with a peritoneal dialysis catheter about the signs and symptoms of peritonitis. Which teaching statements will the nurse include? **Select all that apply**.
A) "Monitor your temperature and report any fever."
B) "Monitor your urine output and report any decrease in output."
C) "Report any nausea or vomiting you may have."
D) "Monitor the insertion site and report any redness."
E) "Report any abdominal pain you may have."
Answer: A, C, D, E
Explanation: A) The nurse should teach the client with a peritoneal dialysis catheter to report any signs and symptoms of peritonitis. These include: fever, nausea, vomiting, redness at the insertion site, or abdominal pain.
B) Decreased urinary output is not uncommon in a client receiving peritoneal dialysis and is not a sign or symptom of peritonitis.
C) The nurse should teach the client with a peritoneal dialysis catheter to report any signs and symptoms of peritonitis. These include: fever, nausea, vomiting, redness at the insertion site, or abdominal pain.
D) The nurse should teach the client with a peritoneal dialysis catheter to report any signs and symptoms of peritonitis. These include: fever, nausea, vomiting, redness at the insertion site, or abdominal pain.
E) The nurse should teach the client with a peritoneal dialysis catheter to report any signs and symptoms of peritonitis. These include: fever, nausea, vomiting, redness at the insertion site, or abdominal pain.
Page Ref: 281
Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Intervention | Learning Outcome: 4.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Relationship Centered Care

19) The nurse plans to assist in the transfer of the client to a bedside commode. Place the procedure steps in the correct order.
A) Place slippers on the client.
B) Place commode at the foot of the bed.
C) Raise the client's head of the bed and move client to the edge of the bed.
D) Safely transfer the client to the commode.
E) Cover client with bath blanket as needed for warmth.
Answer: B, A, C, D, E
Explanation: A) The correct steps for the transfer to a bedside commode is as follows: Place the commode at the foot of the bed, ensuring the wheels are locked; place slippers on the client; raise the client's head of the bed and move the client to the edge of the bed; safely transfer the client to the commode using proper body mechanics; cover the client with a bath blanket as needed for warmth.
B) The correct steps for the transfer to a bedside commode is as follows: Place the commode at the foot of the bed, ensuring the wheels are locked; place slippers on the client; raise the client's head of the bed and move the client to the edge of the bed; safely transfer the client to the commode using proper body mechanics; cover the client with a bath blanket as needed for warmth.
C) The correct steps for the transfer to a bedside commode is as follows: Place the commode at the foot of the bed, ensuring the wheels are locked; place slippers on the client; raise the client's head of the bed and move the client to the edge of the bed; safely transfer the client to the commode using proper body mechanics; cover the client with a bath blanket as needed for warmth.
D) The correct steps for the transfer to a bedside commode is as follows: Place the commode at the foot of the bed, ensuring the wheels are locked; place slippers on the client; raise the client's head of the bed and move the client to the edge of the bed; safely transfer the client to the commode using proper body mechanics; cover the client with a bath blanket as needed for warmth.

E) The correct steps for the transfer to a bedside commode is as follows: Place the commode at the foot of the bed, ensuring the wheels are locked; place slippers on the client; raise the client's head of the bed and move the client to the edge of the bed; safely transfer the client to the commode using proper body mechanics; cover the client with a bath blanket as needed for warmth.
Page Ref: 244
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Intervention | Learning Outcome: 4.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

20) The nurse prepares to change a client's fecal ostomy pouch. Which assessments regarding the stoma are PRIORITY? **Select all that apply**.
A) Skin around the stoma
B) Location of the stoma
C) Appearance of the stoma
D) Date of stoma placement
E) Complications during placement of stoma
Answer: A, B, C
Explanation: A) When assessing the stoma of a client with a fecal ostomy pouch, the priority assessment includes assessing the skin around the stoma.
B) When assessing the stoma of a client with a fecal ostomy pouch, the location of the stoma should be assessed.
C) When assessing the stoma of a client with a fecal ostomy pouch, the priority assessment includes assessing the appearance of the stoma itself.
D) The date the stoma was placed does not need to be assessed when changing the fecal ostomy pouch.
E) Any complications during the placement of the stoma are not priority when changing the fecal ostomy pouch.
Page Ref: 272
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 4.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

Clinical Nursing Skills: A Concept-Based Approach, 4e (Pearson)
Chapter 5 Fluids and Electrolytes

1) The nurse prepares to change the client's central line dressing. Place the steps of the procedure in correct order.
A) Remove the old dressing.
B) Remove and discard gloves; perform hand hygiene.
C) Don a mask and have the client don a mask.
D) Apply the new dressing.
E) Cleanse the site.
Answer: C, A, B, E, D
Explanation: A) The correct steps for performing a central line dressing change is as follows: don a mask and have the client don a mask; remove the old dressing; remove and discard gloves; perform hand hygiene; cleanse the site; apply the new dressing.
B) The correct steps for performing a central line dressing change is as follows: don a mask and have the client don a mask; remove the old dressing; remove and discard gloves; perform hand hygiene; cleanse the site; apply the new dressing.
C) The correct steps for performing a central line dressing change is as follows: don a mask and have the client don a mask; remove the old dressing; remove and discard gloves; perform hand hygiene; cleanse the site; apply the new dressing.
D) The correct steps for performing a central line dressing change is as follows: don a mask and have the client don a mask; remove the old dressing; remove and discard gloves; perform hand hygiene; cleanse the site; apply the new dressing.
E) The correct steps for performing a central line dressing change is as follows: don a mask and have the client don a mask; remove the old dressing; remove and discard gloves; perform hand hygiene; cleanse the site; apply the new dressing.

Page Ref: 297
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 5.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

2) The nurse prepares to administer a medication through the client's central line. Per hospital policy, the nurse must use heparin to keep the line patent. Place the steps in the correct order for administering medication through the central line.
A) Administer the medication.
B) Flush the catheter with 5-mL saline.
C) Flush the catheter with heparin.
D) Flush the catheter with 10-mL saline.
Answer: D, A, B, C
Explanation: A) The process to administer medication through the central line is as follows: flush the catheter with 10-mL saline; administer the medication; flush the catheter with 5-mL saline; flush the catheter with heparin.
B) The process to administer medication through the central line is as follows: flush the catheter with 10-mL saline; administer the medication; flush the catheter with 5-mL saline; flush the catheter with heparin.
C) The process to administer medication through the central line is as follows: flush the catheter with 10-mL saline; administer the medication; flush the catheter with 5-mL saline; flush the catheter with heparin.
D) The process to administer medication through the central line is as follows: flush the catheter with 10-mL saline; administer the medication; flush the catheter with 5-mL saline; flush the catheter with heparin.
Page Ref: 302
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 5.8 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Relationship Centered Care

3) The nurse cares for a client who is sedated, intubated, mechanically ventilated, and has a central line. While repositioning the client, the central line is disrupted. Place the steps in correct order in response to the clinical scenario.
A) Place the client in supine position.
B) Clamp the affected lumen with a soft-tipped clamp.
C) Place a strip of tape over the catheter.
D) Notify the healthcare provider.
Answer: A, C, B, D
Explanation: A) If a central line is disrupted, the nurse should first have the client perform the Valsalva maneuver. However, this client is unable to do so. In this case, the correct steps are as follows: place the client in supine position; place a strip of tape over the catheter; clamp the affected lumen with a soft-tipped clamp; notify the healthcare provider.
B) If a central line is disrupted, the nurse should first have the client perform the Valsalva maneuver. However, this client is unable to do so. In this case, the correct steps are as follows: place the client in supine position; place a strip of tape over the catheter; clamp the affected lumen with a soft-tipped clamp; notify the healthcare provider.
C) If a central line is disrupted, the nurse should first have the client perform the Valsalva maneuver. However, this client is unable to do so. In this case, the correct steps are as follows: place the client in supine position; place a strip of tape over the catheter; clamp the affected lumen with a soft-tipped clamp; notify the healthcare provider.
D) If a central line is disrupted, the nurse should first have the client perform the Valsalva maneuver. However, this client is unable to do so. In this case, the correct steps are as follows: place the client in supine position; place a strip of tape over the catheter; clamp the affected lumen with a soft-tipped clamp; notify the healthcare provider.

Page Ref: 301
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 5.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

4) The nurse is teaching a client of the importance of monitoring intake and output at home. Which statement will the nurse include in the client teaching?
A) "Weigh at two different times during the day in order to see a change."
B) "If your weight goes up more than one pound in a day, contact your healthcare provider."
C) "If you notice sticky mucus membranes, contact your healthcare provider."
D) "Weigh with two different scales in order to compare results."
Answer: C
Explanation: A) The nurse should teach the client to weigh at the same time during the day.
B) The nurse will teach the client that if their weight goes up by more than 0.9-1.3 kg (2-3 lb.) per day to contact the healthcare provider.
C) Sticky mucus membranes may indicate a fluid volume deficit and the client should report this finding to the healthcare provider.
D) The nurse should teach the client to weigh using the same scale in order to provide accurate weights.
Page Ref: 295
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Intervention | Learning Outcome: 5.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Relationship Centered Care

5) The nurse is assisting the healthcare provider to insert a central line for the client. During the procedure, the client reports sudden shortness of breath and the client's SpO_2 falls to 88% on room air. Which actions will the nurse take? **Select all that apply**.

A) Place the client in the left side-lying position.
B) Lower the client's head of the bed.
C) Raise the client's head of the bed.
D) Apply 100% oxygen via mask.
E) Prepare for intubation and mechanical ventilation.
Answer: A, B, D
Explanation: A) The client is likely experiencing an air embolism, a potential complication of central line placement. The nurse should place the client in the left Trendelenburg position (side-lying).
B) The head of the bed should be lowered.
C) The head of the bed should not be elevated.
D) Oxygen 100% via mask should be applied.
E) Although the client is experiencing shortness of breath, the nurse will not yet prepare for intubation and mechanical ventilation.
Page Ref: 302
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 5.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

6) The nurse plans teaching for the client on methods of encouraging fluid intake. Which statements will the nurse include? **Select all that apply**.
A) "Consume 180 mL of water daily."
B) "Limit your alcohol intake."
C) "Avoid excess amounts of fluids high in salt."
D) "Moderate caffeine intake is acceptable."
E) "Consume 6-8 glasses of water daily."
Answer: B, C, E
Explanation: A) Consuming 180 mL of fluid is not enough fluid intake.
B) Alcohol can be a diuretic and should be avoided.
C) When teaching a client on methods of encouraging fluid intake, the nurse will suggest the client avoid excess amounts of fluids high in salt.
D) Caffeine promotes diuresis and should be discouraged.
E) When teaching a client on methods of encouraging fluid intake, the nurse will suggest the client consume 6-8 glasses of water daily.
Page Ref: 295
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Intervention | Learning Outcome: 5.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Relationship Centered Care

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7) The nurse prepares to insert an intravenous catheter in an older adult client. Which action should the nurse take?
A) Use a tourniquet prior to assessing the insertion site.
B) Keep a tourniquet applied until the infusion set is attached.
C) Insert the catheter in a distal vein.
D) Insert the catheter in a proximal vein.
Answer: C
Explanation: A) A tourniquet may not be required.
B) A tourniquet may not be necessary and if used, should be applied loosely for a short period of time.
C) The nurse should insert a small-gauge, short catheter in the distal vein first to preserve proximal vessel.
D) Distal veins should be used before proximal veins.
Page Ref: 306
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 5.5 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Relationship Centered Care

8) The nurse is caring for a client who is receiving intravenous therapy with an infusion pump. An occlusion alarm sounds. Which things will the nurse check? **Select all that apply**.
A) IV site
B) Pinched tubing
C) Closed clamp
D) Client positioning
E) Bubbles in the tubing
Answer: A, B, C, D
Explanation: A) An occlusion alarm is a common alarm that sounds on the infusion pump. This occurs when the pump cannot maintain delivery in the face of increasing resistance. The nurse should check the IV site for infiltration.
B) An occlusion alarm is a common alarm that sounds on the infusion pump. This occurs when the pump cannot maintain delivery in the face of increasing resistance. The nurse should check for pinched tubing.
C) An occlusion alarm is a common alarm that sounds on the infusion pump. This occurs when the pump cannot maintain delivery in the face of increasing resistance. The nurse should check the clamps for closures.
D) An occlusion alarm is a common alarm that sounds on the infusion pump. This occurs when the pump cannot maintain delivery in the face of increasing resistance. The nurse should check the client positioning.
E) Bubbles in the tubing causes an air in the tubing warning.
Page Ref: 307-308
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Assessment | Learning Outcome: 5.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Relationship Centered Care

9) The nurse prepares to change the client's central line dressing and replace the injection cap. In which position will the nurse place the client?

A) Supine
B) Upright
C) High-Fowler
D) Side-lying

Answer: A

Explanation: A) The client should be positioned in the supine position.
B) Head of bed elevation increases the chances of an air embolism forming.
C) High-Fowler is not the correct position to change the dressing or replace the injection cap.
D) The side-lying position is not the correct position to change the dressing or replace the injection cap.

Page Ref: 297
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 5.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

10) The nurse needs to obtain blood samples from the client's central line for blood analysis. Place the steps of the procedure in correct order.
A) Withdraw 10 mL of blood and discard.
B) Flush with 5 mL normal saline.
C) Inject 5mL heparin.
D) Draw up the required blood and transfer to the appropriate containers.
E) Clean the infusion access port according to policy for 10 seconds.
F) Clean the infusion access port according to policy for 30 seconds.
Answer: F, A, D, E, B, C
Explanation: A) The steps of obtaining blood for analysis while drawing from a central line is as follows: clean the infusion access port according to policy for 30 seconds; withdraw 10 mL of blood and discard; draw up the required blood and transfer to the appropriate containers; clean the infusion access port according to policy for 10 seconds; flush with 5 mL normal saline; inject 5 mL heparin.
B) The steps of obtaining blood for analysis while drawing from a central line is as follows: clean the infusion access port according to policy for 30 seconds; withdraw 10 mL of blood and discard; draw up the required blood and transfer to the appropriate containers; clean the infusion access port according to policy for 10 seconds; flush with 5 mL normal saline; inject 5 mL heparin.
C) The steps of obtaining blood for analysis while drawing from a central line is as follows: clean the infusion access port according to policy for 30 seconds; withdraw 10 mL of blood and discard; draw up the required blood and transfer to the appropriate containers; clean the infusion access port according to policy for 10 seconds; flush with 5 mL normal saline; inject 5 mL heparin.

D) The steps of obtaining blood for analysis while drawing from a central line is as follows: clean the infusion access port according to policy for 30 seconds; withdraw 10 mL of blood and discard; draw up the required blood and transfer to the appropriate containers; clean the infusion access port according to policy for 10 seconds; flush with 5 mL normal saline; inject 5 mL heparin.
E) The steps of obtaining blood for analysis while drawing from a central line is as follows: clean the infusion access port according to policy for 30 seconds; withdraw 10 mL of blood and discard; draw up the required blood and transfer to the appropriate containers; clean the infusion access port according to policy for 10 seconds; flush with 5 mL normal saline; inject 5 mL heparin.
F) The steps of obtaining blood for analysis while drawing from a central line is as follows: clean the infusion access port according to policy for 30 seconds; withdraw 10 mL of blood and discard; draw up the required blood and transfer to the appropriate containers; clean the infusion access port according to policy for 10 seconds; flush with 5 mL normal saline; inject 5 mL heparin.
Page Ref: 304
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 5.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Quality & Safety

11) Calculate the flow rate of the following intravenous therapy prescription:

3 liters 09.% normal saline over 24 hours.

A) 125 mL/hr
B) 100 mL/hr
C) 250 mL/hr
D) 90 mL/hr
Answer: A
Explanation: A) The formula for calculating flow rate is as follows:

$$\frac{\text{Total IV fluid mL}}{\text{Total hours to run}} = \text{mL/hr}$$

$$3\text{L} = \frac{3{,}000 \text{ mL}}{24} = 125 \text{ mL/hr}$$

B) This is not the correct calculation.
C) This is not the correct calculation.
D) This is not the correct calculation.
Page Ref: 308
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 5.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Relationship Centered Care

12) The nurse is setting up an intravenous infusion for a client and the nurse has set the IV pump according to the health care provider's orders. In which way will the nurse BEST verify that the drops/minute rate is correct?
A) Verify the tubing size and adjust accordingly.
B) Verify the flow rate on the infusion pump.
C) Count the drops in the drip chamber for 6 seconds and multiply by 10.
D) Count the drops in the drip chamber for 15 seconds and multiply by 4.
Answer: D
Explanation: A) Verifying the tubing size does not determine the drops/minute is correct.
B) Verifying the flow rate does not determine the drops/minute is correct.
C) Counting the drops for 6 seconds and multiplying by 10 is incorrect.
D) In order to verify that the drops/minute rate is correct, the nurse will count the drops in the drip chamber for 15 seconds and multiply by 4.
Page Ref: 309
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 5.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 2.7 Evaluate outcomes of care.
NLN Competencies: Relationship Centered Care

13) The nurse cares for a client with a PICC line that requires a dressing change. Place the procedure steps the nurse will perform in the correct order.
A) Remove old transparent dressing.
B) Discard old dressing and gloves.
C) Perform hand hygiene and don clean gloves.
D) Assess the exit site.
E) Perform hand hygiene and don sterile gloves.
F) Clean the exit site and catheter with antimicrobial swabs; allow to dry.
G) Place securement device and cover exit site with transparent dressing.
Answer: C, A, D, B, E, F, G
Explanation: A) The correct steps to perform a PICC dressing change is as follows: Perform hand hygiene and don clean gloves; remove old transparent dressing; assess the exit site; discard the old dressing and gloves; perform hand hygiene and don sterile gloves; clean the exit site and catheter with antimicrobial swabs and allow to dry; place securement device and cover exit site with a transparent dressing.
B) The correct steps to perform a PICC dressing change is as follows: Perform hand hygiene and don clean gloves; remove old transparent dressing; assess the exit site; discard the old dressing and gloves; perform hand hygiene and don sterile gloves; clean the exit site and catheter with antimicrobial swabs and allow to dry; place securement device and cover exit site with a transparent dressing.
C) The correct steps to perform a PICC dressing change is as follows: Perform hand hygiene and don clean gloves; remove old transparent dressing; assess the exit site; discard the old dressing and gloves; perform hand hygiene and don sterile gloves; clean the exit site and catheter with antimicrobial swabs and allow to dry; place securement device and cover exit site with a transparent dressing.

D) The correct steps to perform a PICC dressing change is as follows: Perform hand hygiene and don clean gloves; remove old transparent dressing; assess the exit site; discard the old dressing and gloves; perform hand hygiene and don sterile gloves; clean the exit site and catheter with antimicrobial swabs and allow to dry; place securement device and cover exit site with a transparent dressing.
E) The correct steps to perform a PICC dressing change is as follows: Perform hand hygiene and don clean gloves; remove old transparent dressing; assess the exit site; discard the old dressing and gloves; perform hand hygiene and don sterile gloves; clean the exit site and catheter with antimicrobial swabs and allow to dry; place securement device and cover exit site with a transparent dressing.
F) The correct steps to perform a PICC dressing change is as follows: Perform hand hygiene and don clean gloves; remove old transparent dressing; assess the exit site; discard the old dressing and gloves; perform hand hygiene and don sterile gloves; clean the exit site and catheter with antimicrobial swabs and allow to dry; place securement device and cover exit site with a transparent dressing.

G) The correct steps to perform a PICC dressing change is as follows: Perform hand hygiene and don clean gloves; remove old transparent dressing; assess the exit site; discard the old dressing and gloves; perform hand hygiene and don sterile gloves; clean the exit site and catheter with antimicrobial swabs and allow to dry; place securement device and cover exit site with a transparent dressing.
Page Ref: 328
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 5.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

14) The nurse removes a client's intravenous catheter and notes the tip of the catheter is broken. The nurse palpates the client's arm and feels the broken piece. Which action should the nurse take?
A) Apply ice to the insertion site.
B) Raise the client's arm above the heart.
C) Apply a pressure dressing on the insertion site.
D) Apply a tourniquet above the insertion site.
Answer: D
Explanation: A) Ice will not help if a catheter tip breaks off in a vein.
B) Raising the arm above the heart will encourage the tip to migrate further up the extremity.
C) A pressure dressing is not appropriate.

D) If the broken piece of a catheter is palpated, the nurse should apply a tourniquet above the tourniquet to decrease the risk of the piece migrating to the heart or lunges.
Page Ref: 306
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 5.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

15) The nurse administers intravenous fluid therapy using a Dial-A-Flo device. Which disadvantage should the nurse identify about this device?
A) It does not control the size of the drops delivered.
B) It does not allow for a fixed flow rate.
C) It does not allow a specified number of drops in the drip chamber.
D) It does not allow visual calculation of the flow rate.
Answer: A
Explanation: A) The Dial-A-Flo device cannot control the size of the drops delivered.
B) The Dial-A-Flow device allows for a fixed flow rate.
C) The Dial-A-Flow device allows a specific number of drops in the drip chamber.
D) This device allows for visual calculation of the flow rate.
Page Ref: 307
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Assessment | Learning Outcome: 5.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Relationship Centered Care

16) The nurse cares for a client with a central venous catheter. Which action by the nurse is incorrect when maintaining the client's central line?
A) Wiping the access port with an antimicrobial swab for 30 seconds.
B) Using a 5-mL syringe to flush the catheter.
C) Flushing the catheter before and after each dose of medication.
D) Using a push-pause-push motion to flush the catheter.

Answer: B
Explanation: A) The nurse will wipe the access port with an antimicrobial swab for at least 30 seconds.
B) When maintaining the client's central line, the nurse will use a 10-mL syringe instead of 5-mL because smaller syringes can exert too much pressure, which can damage the catheter.
C) The nurse will flush the catheter before and after each dose of medication.
D) The nurse will use a push-pause-push motion to flush the catheter.
Page Ref: 301-302
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 5.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

17) The nurse attempts to flush the lumen of a triple lumen central catheter and notes severe resistance to flushing. Which diagnostic procedure does the nurse anticipate when assessing the correct placement of the central line?
A) Chest CT
B) Fluoroscopy
C) Chest X-ray
D) Endoscopy
Answer: C
Explanation: A) The chest CT may be performed; however, this is not the most likely diagnostic test.
B) Fluoroscopy will be performed if an occlusion is suspected.
C) The nurse should anticipate the healthcare provider ordering a chest X-ray when determining the placement of the client's central line.
D) Endoscopy is performed when there are issues with the upper or lower GI system.
Page Ref: 302
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 5.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

18) The nurse cares for a client with an intravenous infusion of D5NS. For which complications will the nurse closely monitor the client? **Select all that apply.**

A) Increased serum sodium
B) Decreased serum potassium
C) Fluid overload
D) Hypotension
E) Increased serum chloride
Answer: A, C, E
Explanation: A) D5NS is a hypertonic intravenous solution, which promotes osmosis of fluid out of the cells. Complications of D5NS therapy is hypernatremia (elevated serum sodium).
B) Hypokalemia is not a complication of D5NS solution.
C) Complications of D5NS therapy include fluid overload.
D) Hypotension is not a complication of D5NS therapy.
E) Complications of D5NS therapy include hyperchloremia (increased serum chloride).
Page Ref: 314
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Assessment | Learning Outcome: 5.2 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

19) The nurse cares for a client with a triple lumen central line who develops a fever, which the nurse suspects is from the central line. Which nursing actions are appropriate? **Select all that apply**.
A) Replace the infusing TPN with normal saline.
B) Change the IV tubing.
C) Remove the IV using sterile technique.
D) Change the IV dressing.
E) Culture the insertion site using sterile technique.
Answer: A, B, D, E
Explanation: A) If the nurse suspects the central line may be the cause of infection, the nurse will replace any nutrition or blood infusing with normal saline.
B) If the nurse suspects the central line may be the cause of infection, the nurse will change the IV tubing.
C) The nurse will not remove the IV without the order of the healthcare provider.
D) If the nurse suspects the central line may be the cause of infection, the nurse will change the dressing.
E) If the nurse suspects the central line may be the cause of infection, the nurse will culture the insertion site using sterile technique.
Page Ref: 302
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 5.5 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

20) A novice nurse performs care of a client's central line. Which action by the novice nurse requires intervention by the nurse preceptor?
A) Changing a clean gauze dressing that is 48 hours old.
B) Changing a clean transparent dressing that is 72 hours old.
C) Scrubbing the insertion site with antimicrobial solution for 30 seconds.
D) Placing an impregnated antimicrobial dressing on the insertion site.
Answer: B
Explanation: A) A gauze dressing for a central line needs to be replaced after 48 hours, even if the dressing is dry and intact.
B) Care of the central line involves ensuring sterile technique and replacing dressings when needed. A clean and intact transparent dressing may be left in place for up to 7 days.
C) Scrubbing the insertion site with antimicrobial solution for 30 seconds is a correct action when caring for a client's central line.
D) Placing an impregnated antimicrobial dressing on the insertion site is a correct action when caring for a client's central line.
Page Ref: 301
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 5.4 | QSEN Competencies: Evidence-Based Practice
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

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21) After removing a client's intravenous catheter from the upper extremity, the nurse notes the client has persistent bleeding despite applying firm pressure. Which action will the nurse take?
A) Hold the client's arm above the level of the heart.
B) Place the client's arm in the dependent position.
C) Lower the client's head of the bed.
D) Apply a tourniquet to the client's arm.
Answer: A
Explanation: A) If bleeding persists after applying firm pressure, the nurse should hold the client's arm above the level of the heart to decrease blood flow to the extremity.
B) The arm in the dependent position may make the bleeding worse.
C) Lowering the head of the bed will have no effect on the amount of bleeding from the catheter insertion site.
D) A tourniquet may make the bleeding worse.
Page Ref: 305
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Intervention | Learning Outcome: 5.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

22) The nurse attempts to secure and stabilize an IV catheter and dressing of an older adult client. Which nursing action is appropriate?
A) Use roll-type gauze to cover the IV site.
B) Apply skin protector solution prior to dressing the IV site.
C) Use extra tape to attach to the client's skin.
D) Apply lotion to the client's skin prior to dressing the IV site.
Answer: B
Explanation: A) Roll-type gauze is not appropriate for this situation.
B) Securing and stabilizing an IV catheter and dressing of an older adult client can be challenging due to the client's fragile skin. The nurse should apply a skin protector solution prior to dressing the IV site to help protect the skin.
C) Tape increases the risk of injury to the skin.
D) Application of lotion would impair, not improve, securing and stabilizing an IV catheter and dressing.
Page Ref: 306
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 5.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Relationship Centered Care

23) The nurse cares for a client with traumatic injuries due to a motor vehicle accident. The nurse wants to increase the intravenous flow rate of intravenous fluids infusing. Which actions will the nurse take? **Select all that apply**.

A) Insert a large bore IV catheter.
B) Warm the IV fluid prior to infusing.
C) Cool the IV fluid prior to infusing.
D) Insert a long IV catheter.
E) Use a macrodrip IV tubing set.
Answer: A, B, E
Explanation: A) There are situations where intravenous fluid therapy needs to be infused rapidly. Methods to improve the rapid infusion of intravenous fluids include inserting a large bore IV catheter.
B) Warm fluids drip faster than cold fluids.
C) Cool fluids infuse slower.
D) Longer IV catheters infuse slower.
E) Using a macrodrip IV tubing set will provide larger drops of fluid per minute.
Page Ref: 307
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 5.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Relationship Centered Care

***Clinical Nursing Skills: A Concept-Based Approach, 4e* (Pearson)**
Chapter 6 Infection

1) The nurse is caring for a client in isolation. The nurse needs to remove the isolation gown and gloves after leaving the client's room. Place the steps in correct order for removing PPE.
A) Remove gloves.
B) Use the nondominant hand to pull sleeve wristlet over the dominant hand.
C) Grasp outside of gown through the sleeves at shoulders.
D) Using the dominant hand and grasping the clean part of the wristlet, pull sleeve wristlet over the nondominant hand.
E) Fold gown inside out and discard.
F) Pull gown down over the arms.
Answer: A, D, B, C, F, E
Explanation: A) The process of removing gloves and gown is as follows: Remove gloves; using the dominant hand and grasping the clean part of the wristlet, pull sleeve wristlet over the nondominant hand; use the nondominant hand to pull sleeve wristlet over the dominant hand; grasp the outside of the gown through the sleeves at the shoulders; pull the gown down over the arms; fold gown inside out and discard.
B) The process of removing gloves and gown is as follows: Remove gloves; using the dominant hand and grasping the clean part of the wristlet, pull sleeve wristlet over the nondominant hand; use the nondominant hand to pull sleeve wristlet over the dominant hand; grasp the outside of the gown through the sleeves at the shoulders; pull the gown down over the arms; fold gown inside out and discard.
C) The process of removing gloves and gown is as follows: Remove gloves; using the dominant hand and grasping the clean part of the wristlet, pull sleeve wristlet over the nondominant hand; use the nondominant hand to pull sleeve wristlet over the dominant hand; grasp the outside of the gown through the sleeves at the shoulders; pull the gown down over the arms; fold gown inside out and discard.
D) The process of removing gloves and gown is as follows: Remove gloves; using the dominant hand and grasping the clean part of the wristlet, pull sleeve wristlet over the nondominant hand; use the nondominant hand to pull sleeve wristlet over the dominant hand; grasp the outside of the gown through the sleeves at the shoulders; pull the gown down over the arms; fold gown inside out and discard.
E) The process of removing gloves and gown is as follows: Remove gloves; using the dominant hand and grasping the clean part of the wristlet, pull sleeve wristlet over the nondominant hand; use the nondominant hand to pull sleeve wristlet over the dominant hand; grasp the outside of the gown through the sleeves at the shoulders; pull the gown down over the arms; fold gown inside out and discard.

F) The process of removing gloves and gown is as follows: Remove gloves; using the dominant hand and grasping the clean part of the wristlet, pull sleeve wristlet over the nondominant hand; use the nondominant hand to pull sleeve wristlet over the dominant hand; grasp the outside of the gown through the sleeves at the shoulders; pull the gown down over the arms; fold gown inside out and discard.
Page Ref: 347
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 6.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

2) The nurse caring for a client in an isolation environment decides to change the isolation mask. For which reason should the nurse change the mask?
A) The effectiveness of the mask decreased.
B) The mask became soiled by the client.
C) The mask was too uncomfortable.
D) The mask did not seal properly.
Answer: A
Explanation: A) An isolation mask should be changed every 30 minutes or sooner because the moisture that accumulates in it decreases its effectiveness.
B) It is unlikely that the client soiled the nurse's mask.
C) A mask may be uncomfortable but that is not a reason to change it.
D) The mask needs to be adjusted to improve the seal and not necessarily changed.
Page Ref: 358
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 6.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

3) The nurse exits the room of a client who is under isolation precautions. The nurse must remove both protective eyewear and a face mask. Place the steps of removing the PPE in the correct order.

A) Untie the upper strings of the mask.

B) Dispose of the mask.

C) Remove the protective eyewear.

D) Untie the lower strings of the mask.

Answer: C, D, A, B

Explanation: A) When removing protective eyewear and face mask, the following steps should be followed: Remove the protective eyewear; untie the lower strings of the mask; untie the upper strings of the mask; remove the mask.

B) When removing protective eyewear and face mask, the following steps should be followed: Remove the protective eyewear; untie the lower strings of the mask; untie the upper strings of the mask; remove the mask.

C) When removing protective eyewear and face mask, the following steps should be followed: Remove the protective eyewear; untie the lower strings of the mask; untie the upper strings of the mask; remove the mask.

D) When removing protective eyewear and face mask, the following steps should be followed: Remove the protective eyewear; untie the lower strings of the mask; untie the upper strings of the mask; remove the mask.

Page Ref: 358

Cognitive Level: Analyzing

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: Nursing Process: Intervention | Learning Outcome: 6.1 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.

NLN Competencies: Quality & Safety

4) The nurse prepares to enter the room of a child who requires isolation precautions. Which actions will the nurse take to ease the child's fears? **Select all that apply.**

A) Introduce self before donning a mask, if possible.

B) Encourage the child to play with the equipment.

C) Visit the client frequently.

D) Group nursing tasks to decrease contact.

E) Encourage the child to walk the halls frequently.

Answer: A, B, C

Explanation: A) A child on isolation precautions is often scared of healthcare providers and the equipment used for isolation. In order to ease the child's fears, the nurse should introduce herself or himself before donning a mask, if possible.

B) Encouraging the child to play with the equipment may decrease the child's fear.

C) Visit the client frequently to establish rapport and get the child familiar with the nurse.

D) Decreasing contact increases the child's social isolation and is not recommended.

E) The child requires isolation precautions and walking the halls may not be appropriate.

Page Ref: 347

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: Nursing Process: Intervention | Learning Outcome: 6.1 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: 2.2 Communicate effectively with individuals.

NLN Competencies: Relationship Centered Care

5) The nurse cares for a client with bacterial meningitis. Which isolation precaution will the nurse apply?

A) Standard

B) Contact

C) Droplet

D) Airborne

Answer: C

Explanation: A) Standard precautions are not a type of isolation.

B) The client does not need contact precautions.

C) Bacterial meningitis is transmitted through tiny droplets of mucus or airway secretions from talking, coughing, and sneezing and the nurse will implement droplet precautions.

D) Airborne precautions are not required.

Page Ref: 345

Cognitive Level: Remembering

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: Nursing Process: Intervention | Learning Outcome: 6.1 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.

NLN Competencies: Quality & Safety

6) A home care nurse is providing teaching to a client regarding infection control precautions at home. Which statement will the nurse include in the teaching?
A) "Discard used dressings in a biohazard bag."
B) "Clothing soiled with blood can be laundered with the rest of your clothing."
C) "Disinfect reusable equipment and supplies with a bleach solution."
D) "If supplies need refrigeration, keep in the door of the fridge away from the light."
Answer: C
Explanation: A) Used dressings should be discarded in the regular trash.
B) Clothing soiled with blood or fluid should be laundered separately from the rest of the laundry.
C) The home care nurse will provide infection control teaching to clients and it is important to understand home care instructions for infection control. Teach the client to disinfect reusable equipment and supplies with a bleach solution.
D) If supplies need refrigeration, the supplies should be kept in a bag and placed in the refrigerator.
Page Ref: 351
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 6.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

7) The nurse reviews the various isolation environments to prevent the spread of disease. Which basic preventive practices are implemented with all clients and others to ensure disease transmission does not happen?
A) Standard
B) Reverse
C) Droplet
D) Airborne
Answer: A
Explanation: A) Standard precautions (previously known as universal precautions) are the basic preventive practices that are implemented with all clients and others to prevent the spread of disease.
B) Reverse isolation is known as neutropenic isolation and occurs when a client is severely immunocompromised.
C) Droplet precautions are implemented when conditions may be spread by respiratory droplets in the air.
D) Airborne precautions are implemented when conditions may be spread through the air.
Page Ref: 340
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 6.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

8) The nurse is caring for a client with cancer who is neutropenic. Which guidelines will the nurse follow regarding neutropenic precautions? **Select all that apply**.
A) Ensure the client does not receive any visitors.
B) Do not allow the client to receive fresh flowers.
C) Inspect the client's food trays to ensure no fresh vegetables are given.
D) Keep the client's door closed.
E) Ensure the client wears an N95 mask when outside of the room.
Answer: B, C, D
Explanation: A) The neutropenic client may receive visitors; however, these should be limited to immediate family only and these visitors must comply with the neutropenic precautions.
B) The nurse should make sure the client does not receive fresh flowers.
C) The nurse should make sure the client does not eat raw vegetables.
D) The nurse should keep the client's door closed.
E) The client who is neutropenic should wear a regular surgical mask when outside the room; an N95 mask is not necessary.
Page Ref: 359
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 6.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

9) The nurse cares for an older adult and recognizes the client is at increased risk for developing infection. Which condition poses the greatest risk of infection in the client?
A) Diabetes mellitus
B) Eczema
C) Glaucoma
D) Emphysema
Answer: A
Explanation: A) Diabetes mellitus, often found in older adult clients, increases the risk of infection and delayed healing.
B) Eczema does not increase the risk of infection in an older adult.
C) Glaucoma does not increase the risk of infection in an older adult.
D) Emphysema does not increase the risk of infection in an older adult.
Page Ref: 351
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Assessment | Learning Outcome: 6.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

10) The nurse cares for a client who acquires a healthcare-associated infection while in an isolation environment. Which action will the infection control nurse take that BEST responds to the client's condition?

A) Plan staff education on isolation precautions and proper hand hygiene.
B) Ask the client if he or she is performing hand hygiene.
C) Examine isolation equipment outside the client's room.
D) Plan staff education on the identification of clients at greatest risk for infection.

Answer: A

Explanation: A) Staff education is the priority when a client acquires a healthcare-associated infection while in an isolation environment. The priority teaching is on the proper use of isolation precautions and correct hand hygiene.

B) Asking the client if he or she is performing hand hygiene does not help respond to the client's condition and the scenario does not indicate if the client is able to perform this action.

C) While it is not inappropriate to examine isolation equipment, this intervention is not the best response to the client's condition and is not the correct answer choice.

D) Education on identification of clients at greatest risk is not the priority because infection control always begins with proper hand hygiene.

Page Ref: 360
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 6.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

11) The nurse must remove soiled equipment from a client's isolation room. Place the steps in correct order of how the nurse will remove the equipment.
A) Place equipment in an isolation bag.
B) Wash equipment with an antimicrobial agent.
C) Perform hand hygiene and don gloves.
D) Remove the isolation bag.
Answer: C, B, A, D
Explanation: A) The process to remove soiled equipment from a client's isolation room is as follows: Perform hand hygiene and don gloves; wash equipment with an antimicrobial agent; place the equipment in an isolation bag; remove the isolation bag.
B) The process to remove soiled equipment from a client's isolation room is as follows: Perform hand hygiene and don gloves; wash equipment with an antimicrobial agent; place the equipment in an isolation bag; remove the isolation bag.
C) The process to remove soiled equipment from a client's isolation room is as follows: Perform hand hygiene and don gloves; wash equipment with an antimicrobial agent; place the equipment in an isolation bag; remove the isolation bag.
D) The process to remove soiled equipment from a client's isolation room is as follows: Perform hand hygiene and don gloves; wash equipment with an antimicrobial agent; place the equipment in an isolation bag; remove the isolation bag.
Page Ref: 353-354
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 6.2 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

12) The nurse cares for a client with norovirus. Which action regarding the isolation precautions should the nurse perform?
A) Using an alcohol-based hand sanitizer after leaving the client's room.
B) Placing the client in a negative-pressure room.
C) Using soap and water only when leaving the client's room.
D) Donning sterile gloves when entering the client's room.
Answer: C
Explanation: A) An alcohol-based hand rub is not effective in removing the pathogens from the hands.
B) The client does not need to be in a negative-pressure room.
C) Enteric contact precautions are used for clients with active infection of pathogens such as C. difficile, rotavirus, or norovirus in the intestinal tract. The pathogens are transmitted in the client's stool. Healthcare personnel must only perform soap and water hand washing.
D) Sterile gloves are not required.
Page Ref: 344
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 6.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

13) A staff nurse asks the charge nurse the difference between airborne and droplet precautions. In which way will the charge nurse respond?

A) "Droplet precautions require the use of an N95 mask, while airborne precautions do not."
B) "Airborne precautions require the use of an N95 mask, while droplet precautions do not."
C) "They are actually the same except some agencies use different terms for these precautions."
D) "Droplet precautions are considered one-tier and airborne precautions are considered two-tier."
Answer: B
Explanation: A) Droplet precautions do not need an N95 mask.
B) Airborne precautions require the use of an N95 mask.
C) Droplet and airborne precautions are not the same.
D) Both precautions are considered two-tier.
Page Ref: 345
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 6.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

14) The nurse cares for a group of clients with infectious diseases or conditions. For which conditions can the nurse use a waterless antiseptic gel for hand hygiene? **Select all that apply**.
A) Clostridium difficile
B) Hepatitis B
C) Norovirus
D) Staphylococcus aureus
E) Escherichia coli
Answer: B, D, E
Explanation: A) Clostridium difficile is not killed by an antiseptic gel. Soap and water is required.
B) Waterless antiseptic hand gels are appropriate for most viruses and bacteria. Hepatitis B is killed by a waterless gel.
C) Norovirus is not killed by an antiseptic gel. Soap and water is required.
D) Staphylococcus aureus is killed by a waterless gel.
E) Escherichia coli is killed by a waterless gel.
Page Ref: 343
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 6.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

15) The nurse is caring for a client suspected of having tuberculosis. The nurse must don an N95 particulate mask. Place the steps in correct order for donning this mask.
A) Position the mask over the mouth and nose.
B) Pull the strap over the head.
C) Pull the shorter strap over the head, below the ears.
D) Hold the mask in the hands with the nosepiece towards the fingertips.
Answer: D, A, B, C
Explanation: A) When donning an N95 particulate mask, the nurse will first hold the mask in the hands with the nosepiece towards the fingertips. Next, the nurse will position the mask over the mouth and nose. Next, the nurse will pull the strap over the head. Finally, the nurse will pull the shorter strap over the head, below the ears.
B) When donning an N95 particulate mask, the nurse will first hold the mask in the hands with the nosepiece towards the fingertips. Next, the nurse will position the mask over the mouth and nose. Next, the nurse will pull the strap over the head. Finally, the nurse will pull the shorter strap over the head, below the ears.
C) When donning an N95 particulate mask, the nurse will first hold the mask in the hands with the nosepiece towards the fingertips. Next, the nurse will position the mask over the mouth and nose. Next, the nurse will pull the strap over the head. Finally, the nurse will pull the shorter strap over the head, below the ears.
D) When donning an N95 particulate mask, the nurse will first hold the mask in the hands with the nosepiece towards the fingertips. Next, the nurse will position the mask over the mouth and nose. Next, the nurse will pull the strap over the head. Finally, the nurse will pull the shorter strap over the head, below the ears.
Page Ref: 358

Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 6.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

16) The nurse needs to remove an isolation gown that slips over the head. In which way will the nurse remove the gown?
A) Pull the shoulders forward to loosen the Velcro at the neck.
B) Tear the gown at the neck.
C) Pull the sleeves over the hands to loosen the gown.
D) Pull the gown over the head inside out.
Answer: A
Explanation: A) Some isolation gowns slip over the head instead of tying at the neck. When removing this type of gown, the nurse will pull the shoulders of the gown forward to loosen the Velcro at the neck. The nurse will then remove the gown in the manner as if the gown were tied in the back.
B) The gown is not torn at the neck.
C) The sleeves are not pulled over the hands to loosen the gown.
D) The gown is not pulled over the head inside out.
Page Ref: 347
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 6.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

17) A novice nurse works with a nurse preceptor on a busy medical surgical unit. Which action by the novice nurse requires intervention by the nurse preceptor when observing the novice nurse performing hand hygiene?
A) Washing hands with warm soapy water for 15 seconds.
B) Using a waterless foam sanitizer before entering the room of a client.
C) Cleaning under the fingernails with an orangewood stick.
D) Drying hands thoroughly with fingers pointing up.
Answer: A
Explanation: A) The novice nurse should wash hands with warm soapy water for at least 20 seconds, not 15. Inadequate washing time decreases the efficacy of hand hygiene.
B) Using a waterless foam sanitizer before entering the room of a client is appropriate.
C) Cleaning under the fingernails with an orangewood stick is appropriate.
D) Drying hands thoroughly with fingers pointing up is appropriate.
Page Ref: 342
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 6.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

18) The nurse teaches an older adult client on methods of infection control. Which statement, specific to this client population, will the nurse include in the teaching?
A) "Ensure increased protein intake in order to maintain immune function."
B) "Inflammatory response increases with age."
C) "Immune function remains unchanged with age."
D) "Ensure adequate protein intake in order to maintain immune function."
Answer: D
Explanation: A) Increasing protein is not required.
B) Inflammatory responses decrease with age.
C) Immune function decreases with age.
D) In order to promote methods of infection control in the older adult, the nurse will encourage adequate (not increased) protein intake in an effort to maintain immune function.
Page Ref: 351
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Intervention | Learning Outcome: 6.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Relationship Centered Care

19) The nurse is removing gloves after performing client care activities. Place the steps in correct order for removing gloves.
A) Pull off one glove by touching the outside of the glove at the cuff.
B) Slip one finger of ungloved hand under glove cuff of other hand.
C) Pull down and off so both gloves are removed as one.
D) Roll up glove and place in gloved hand.

Answer: A, D, B, C
Explanation: A) When removing gloves, pull off one glove by touching the outside of the glove at the cuff; roll up the glove and place in the gloved hand; slip one finger of the ungloved hand under the glove cuff of the other hand; pull down and off so both gloves are removed as one.
B) When removing gloves, pull off one glove by touching the outside of the glove at the cuff; roll up the glove and place in the gloved hand; slip one finger of the ungloved hand under the glove cuff of the other hand; pull down and off so both gloves are removed as one.
C) When removing gloves, pull off one glove by touching the outside of the glove at the cuff; roll up the glove and place in the gloved hand; slip one finger of the ungloved hand under the glove cuff of the other hand; pull down and off so both gloves are removed as one.
D) When removing gloves, pull off one glove by touching the outside of the glove at the cuff; roll up the glove and place in the gloved hand; slip one finger of the ungloved hand under the glove cuff of the other hand; pull down and off so both gloves are removed as one.
Page Ref: 356
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 3.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

Clinical Nursing Skills: A Concept-Based Approach, 4e (Pearson)
Chapter 7 Intracranial Regulation

1) The nurse is completing a Glasgow Coma Scale reassessment of a client who fell down a flight of stairs 8 hours ago. On admission, the client displayed spontaneous eye opening. Which action should the nurse take when conducting a reassessment 4 hours later?
A) Provide painful stimuli to evoke eye opening.
B) Request the client speak his own name.
C) Tell the client to "open his eyes" or to look at the nurse.
D) Ask the client to squeeze the nurse's hand.
Answer: C
Explanation: A) Painful stimuli is not used to open the eyes.
B) Asking the client to state their name is not an action to assess for eye opening.
C) If the client doesn't spontaneously open his eyes, the nurse should ask the client to open his eyes.
D) Squeezing the hand assesses for motor response.
Page Ref: 363
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 7.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

2) The nurse is assessing an older adult client in a long-term care facility who has Alzheimer disease and who has fallen and has a head laceration. For which reason will the nurse avoid using the Glasgow Coma Scale to assess this client?
A) The client is in a long-term care facility.
B) The client is an older adult.
C) The client has a head laceration.
D) The client has been diagnosed with Alzheimer disease.
Answer: D
Explanation: A) The scale can be used for residents in long-term care facilities.
B) The scale can be used for older adults.
C) The scale can be used for clients with head lacerations.
D) The client's Alzheimer disease hampers the nurse's ability to fully assess the client's responses on the Glasgow Coma Scale.
Page Ref: 362
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 7.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

3) An older resident of a long-term care facility falls but does not report that the head was injured. Which are the first signs that the nurse will note if this client has sustained a closed head injury? **Select all that apply.**

A) Spontaneous vomiting
B) Bradycardia
C) Vertigo
D) Headache
E) Widened pulse pressure
Answer: A, C, D
Explanation: A) Vomiting without nausea is an early sign of ICP.
B) Bradycardia is a late sign of increased intracranial pressure.
C) Vertigo is an early sign of ICP.
D) Headache is an early sign of ICP.
E) Widened pulse pressure is a late sign of increased intracranial pressure.
Page Ref: 366
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 7.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

4) An older adult with a minor head injury reports having a headache and dizziness. Which interventions would be most helpful to this client in preventing a possible increase in intracranial pressure?

A) Place the client in a room near the nurse's station.
B) Encourage the client to visit with friends and family to prevent boredom.
C) Dim the lights in the room and encourage the client to rest.
D) Place the client in a supine position with both legs elevated slightly.
Answer: C
Explanation: A) The client does not need to be in a room near the nurse's station.
B) Family visitors should be limited to reduce stimulation.
C) The client should be encouraged to rest and the environment should encourage that rest.
D) The supine position with legs elevated will increase intracranial pressure.
Page Ref: 367
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 7.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

5) An older adult client who sustained a closed head injury approximately 4 hours ago denied any pain or other symptoms at the time of the injury. Which statement by the client would cause the MOST concern to the nurse?
A) "Who are you? Why do you keep asking me my name?"
B) "I wish the nurses would stop coming in and shining a light in my eyes. It's annoying."
C) "This is so silly. I really don't see why all of this is necessary."
D) "Please let me go home. I will come back if I have any problems."
Answer: A
Explanation: A) A very early sign of increased ICP is a slight change in level of consciousness. The client does not appear to recognize the nurse or understand why the assessments are being done.
B) A penlight is used to assess pupillary reaction.
C) Saying that care is silly is not concerning.
D) Requesting to go home is not concerning.
Page Ref: 366
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 7.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

6) The UAP is going to hold an infant in a side-lying position in preparation for a lumbar puncture. Which explanation is the BEST to help the UAP understand why the infant should be flexed to expose and curve the spine?

A) "This position decreases pain for the infant while this procedure is performed."
B) "This position must be maintained because it gives the healthcare provider the best access to the infant's spinal column."
C) "This is the position in which the healthcare provider requested that the infant be placed."
D) "This position prevents contamination of the lumbar puncture site if the infant urinates or defecates during the procedure."
Answer: B
Explanation: A) The position does not decrease pain.
B) Flexing the infant's spine by holding the neck and the legs is the best way to ensure that the healthcare provider has the best and safest access to the infant's spinal column.
C) This position was not requested by the healthcare provider.
D) This position is not used to prevent contamination by urine or stool.
Page Ref: 368
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 7.2 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

7) A 2-year-old child is in a flexed position for a lumbar puncture. Which vital sign will the nurse monitor to detect any abnormality caused by the child's position?
A) Temperature
B) Heart rate
C) Respirations
D) Blood pressure
Answer: C
Explanation: A) The position for a lumbar puncture will not affect the temperature.
B) The position for a lumbar puncture will not affect heart rate.
C) Respirations may be affected because the child's flexed position may impair the ability to adequately breathe.
D) The position for a lumbar puncture will not affect blood pressure.
Page Ref: 368
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 7.2 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

8) A 9-month-old infant who is irritable and has an elevated temperature needs a lumbar puncture. Which staff member would be the BEST one to assist in this procedure?
A) An RN who graduated from nursing school 6 weeks ago
B) A UAP with 9 years of experience in caring for older clients
C) A UAP with 2 years of experience on a pediatric unit
D) An LPN who has been licensed for 4 years but has only worked on the unit for 2 weeks

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Answer: C
Explanation: A) The new RN can delegate this action to someone else.
B) The UAP with experience caring for older clients would not be the best staff member to assist with this procedure.
C) The UAP has 2 years of experience working with infants and children and would be the best choice for holding the infant during the procedure.
D) The LPN who has only worked on the unit for 2 weeks does not have enough experience to hold the 9-month-old infant.
Page Ref: 369
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Planning | Learning Outcome: 7.2 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

9) A client sustained a possible head injury during a motor vehicle crash. Which client precondition would prevent the nurse from using the Glasgow Coma Score?
A) The client is blind.
B) The client is deaf.
C) The client had a previous brain attack.
D) The client has diabetes mellitus.
Answer: B
Explanation: A) The GCS could be used if a client is blind.
B) It would be very difficult for the nurse to use the GCS with a client who is deaf because the tool requires the client to hear the nurse and respond.
C) The GCS could be used if a client has a history of a brain attack.
D) The GCS could be used if a client has diabetes mellitus.
Page Ref: 362
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Assessment | Learning Outcome: 7.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

10) A client with a suspected head injury does not respond when the light is turned on in the room. Which action should the nurse take to assess the client with the Glasgow Coma Scale (GSA)?
A) Complete the client's vital signs and recheck the client in 30 minutes.
B) Gently touch the client's arm to see if the client spontaneously awakens.
C) Turn the light off, leave the room, and document that the client is sleeping.
D) Vigorously rub the client's sternum to determine if the client responds to painful stimuli.
Answer: B
Explanation: A) The client does not need vital signs assessed.
B) The nurse should first attempt to gently awaken the client by touching the arm. If the client awakens with this, the nurse would continue with the GCS and neuro check.
C) The client needs to be assessed and not documented as being asleep.
D) The sternum does not need to be rubbed as a type of painful stimuli.
Page Ref: 363
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 7.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

11) A client being mechanically ventilated after receiving a traumatic head injury while being stabbed has both hands restrained. For which reason will the nurse be unable to complete a Glasgow Coma Score (GCS)?
A) The client is intubated.
B) The client's hands are restrained.
C) The client was stabbed.
D) The client has a traumatic head injury.
Answer: A
Explanation: A) Because the client is intubated, the nurse will be unable to get a verbal response, which is a part of the GCS.
B) The GCS can be used if the client's hands are restrained.
C) The GCS can be used if the client was stabbed.
D) The GCS can be used if the client has a traumatic head injury.
Page Ref: 362
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 7.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

12) A client with diabetic ketoacidosis is demonstrating a deterioration in level of consciousness. Which assessments are a component of both the Glasgow Coma Score and the Full Outline of Un-Responsiveness (FOUR Score) Coma Scale when assessing this client? **Select all that apply.**

A) Brainstem reflexes
B) Ability to follow verbal commands
C) Abnormal breathing patterns
D) Pupil size
E) Types of motor responses
Answer: B, E
Explanation: A) Brainstem reflexes are a part of the FOUR score.
B) Both the FOUR Score Coma Scale and the GCS use the client's ability to follow commands as a component of the assessment.
C) Breathing pattern is a part of the FOUR score.
D) Pupil size is a part of the FOUR score.
E) Motor response is a component of both the GCS and the FOUR Coma Scale.
Page Ref: 364
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 7.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

13) A client is being prepared for a lumbar puncture. For which reason should the nurse ask another nurse to assist in the procedure?
A) Administer pain medication to the client
B) Encourage the client to lie as still as possible
C) Ensure that the healthcare provider maintains sterile technique
D) Take over holding the client when the first nurse gets tired
Answer: B
Explanation: A) Another nurse is not needed to provide pain medication to the client.
B) Providing encouragement to the client helps the client hold still, which is necessary for safety in the procedure.
C) Another nurse is not needed to ensure the healthcare provider maintains sterile technique.
D) Another nurse is not needed to take over if the first nurse becomes fatigued.
Page Ref: 369
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 7.8 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

14) A UAP is assisting a client to stay in the proper position for a lumbar puncture. Which parts of the client's body should the nurse ensure the UAP is supporting?
A) Behind the client's neck and knees
B) Behind the client's neck and feet
C) Under the client's arms and knees
D) Around the client's neck and behind the knees
Answer: A
Explanation: A) The hands should be placed behind the client's neck and knees with the client in a fetal position.
B) The feet are not supported for a lumbar puncture.
C) The arms are not supported for a lumbar puncture.
D) There is no reason to support around the client's neck.
Page Ref: 368
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 7.8 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

15) The healthcare provider is preparing to perform a lumbar puncture on a 5-year-old child and requests that the child be placed in a sitting position. In which way will the nurse assist the child to maintain this position?
A) Tell the child to curl up in a ball and grab onto his feet and hold very still.
B) Inform the healthcare provider that the child is too young to do the procedure in a sitting position and that the procedure must be performed with the child lying down.
C) Assist the child to curl the body over a pillow and help the child stay in this position by stabilizing the child's neck with one hand and the child's knees with another hand.
D) Request another nurse assist so that one nurse can hold the child's neck and head in the curved position and the other nurse can assist the child to hold the knees steady.
Answer: D
Explanation: A) Telling the child to curl up in a ball and hold the feet does not ensure an appropriate position.
B) The puncture can be done with the child in a seated position.
C) A pillow is not used when positioning a child for a lumbar puncture.
D) For a child to be assisted to maintain the seated position for a lumbar puncture, it requires at least two people: one to help the child hold still at the head and the other to help the child hold still at the knees.
Page Ref: 368
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 7.8 | QSEN Competencies: Quality
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

16) The parent of a 6-month-old infant does not want to leave the baby during a lumbar puncture. Which response should the nurse make?
A) "We can't take the chance that you will faint during the procedure. We are here to care for your child, not you."
B) "I realize that you are upset, but this is a sterile procedure and there is an increased chance your child will get an infection if you insist on staying in the room."
C) "I know this must be stressful with your child so sick. Would you like to help hold her in the correct position or would you just like to talk quietly to her during the procedure?"
D) "Our facility's policy is that no one can be in the room except for medical personnel. Besides, you don't want your baby to blame you for all of this."
Answer: C
Explanation: A) There is no evidence that the parent will faint.
B) The parent is not going to cause an infection by being present.
C) If the parent would like to be present, the nurse should give the parent the choice of what they would like to do to assist with the procedure.
D) Saying that the parent would be blamed for the baby needing a lumbar puncture is inappropriate.
Page Ref: 368
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 7.8 | QSEN Competencies: Quality
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

17) A client with increased intracranial pressure has an ICP transducer system. In which position will the nurse place the client to support the client's condition?
A) Left lateral, bed flat
B) Supine, head midline, head of bed elevated 30 degrees
C) Right lateral, head of bed elevated 60 degrees
D) Supine, head midline, bed in Trendelenburg
Answer: B
Explanation: A) The client should not be placed in the left later bed flat position.
B) The best position for the client who has an ICP transducer system to monitor the client's intracranial pressure is supine, head midline, and the head of the bed elevated 15 to 30 degrees. This position prevents compression of blood vessels in the neck and obstruction of venous blood flow.
C) The right lateral position is not appropriate and the head of the bed does not need to be elevated 60 degrees.
D) The client should not be in the Trendelenburg position as this will increase intracranial pressure.
Page Ref: 367
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Intervention | Learning Outcome: 7.6 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

18) The nurse is monitoring a client with an ICP transducer. Which waveform indicates that the client's condition is worsening?
A) Narrow amplitude waveform
B) Appearance of plateau waveforms
C) Increased ICP for 2 minutes
D) ICP pressure of 4-20
Answer: B
Explanation: A) A narrow amplitude waveform is of no clinical significance.
B) The appearance of plateau waveforms indicates the client's condition is deteriorating.
C) Increased ICP for 2 minutes is of no clinical significance.
D) An ICP pressure of 4-20 is of no clinical significance.
Page Ref: 367
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 7.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

19) A client with a diagnosed closed head injury is having intracranial pressure monitoring. Which findings indicate that the client's intracranial pressure is rising? **Select all that apply.**
A) "Doll's eyes" when assessing the client's pupils.
B) Eupnea in respect to respiratory effort.
C) All extremities are flaccid.
D) Blood pressure is stable.
E) Client is in a comatose state.
Answer: A, C, E
Explanation: A) Doll's eyes is a pupillary sign that indicates a worsening ICP.
B) Eupnea is a normal finding.
C) Flaccid extremities are a sign of worsening ICP.
D) Stable blood pressure is a normal finding.
E) A comatose state indicates worsening ICP.
Page Ref: 365
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 7.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

20) During a lumbar puncture the nurse notes an infant's cerebrospinal fluid is cloudy. Which action should the nurse take?
A) Prepare to send the infant for a CT scan to look for an area of bleeding.
B) Assess the infant's anterior fontanel for any bulging.
C) Place the child in respiratory isolation because of an infection.
D) Administer an antipyretic and prepare to send the infant home.
Answer: C
Explanation: A) There is no blood in the cerebrospinal fluid.
B) There is no evidence that the infant's anterior fontanel is bulging.
C) The presence of cloudy fluid is indicative of infection, so the child should be placed in isolation until the type of infection can be determined.
D) The infant should not be discharged until the type of infection is treated.
Page Ref: 369
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 7.5 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

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Clinical Nursing Skills: A Concept-Based Approach, 4e (Pearson)
Chapter 8 Metabolism

1) The nurse is interviewing a client with a suspected endocrine disorder. Which question by the nurse would BEST obtain subjective data related to this client's possible diagnosis?
A) "I noticed that your blood pressure is 98/76 today. Was it this low the last time your blood pressure was measured?"
B) "Can you tell me more about the tingling you are experiencing in your feet?"
C) "Your skin appears very tanned. Did you recently go to the beach?"
D) "Does your face twitch when you touch your cheek?
Answer: B
Explanation: A) Low blood pressure can be caused by medications or another health problem.
B) A client's description of a tingling feeling is subjective data.
C) Tanned skin would help assess an adrenal gland disorder.
D) Facial twitching is associated with a calcium imbalance.
Page Ref: 376
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 8.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

2) The client calls the clinic complaining of an unusual problem. Which client statement to the nurse is most suggestive of a subjective symptom related to an endocrine problem?
A) "I don't have as much energy as I used to. I get out of breath going up stairs."
B) "Recently I have noticed little purple spots on my legs."
C) "All I want to eat are salty things and I'm adding salt to everything I eat."
D) "My belly seems to be growing bigger every day and it's hard to breathe."
Answer: C
Explanation: A) Shortness of breath can be caused by many health conditions.
B) Bruising is associated with a bleeding disorder.
C) Salt cravings is suggestive of Addison disease, an endocrine disorder.
D) Ascites can be caused by many health problems.
Page Ref: 377
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 8.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

3) The nurse is conducting an initial assessment of a client with an endocrine disorder. Which signs and symptoms should the nurse identify as subjective, as opposed to objective? **Select all that apply.**
A) There is 2+ edema present in both hands and feet.
B) The client complains of feeling tired most of the time.
C) The client states that he can't see as well as before.
D) The client's vision measured as 20/200.
E) The client reports very dry skin.
Answer: B, C, E
Explanation: A) Edema would be an objective finding.
B) A complaint of feeling tired is subjective.
C) Complaining of decreased visual acuity is a subjective symptom.
D) Vision measured as 20/200 is an objective finding.
E) Client report of dry skin is a subjective symptom.
Page Ref: 376
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 8.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

4) A client asks how the thyroid gland can be overactive when the thyroid-stimulating hormone level is low. In which way should the nurse respond to this client?

A) "You are correct. We should have said that your thyroid was underactive, not overactive."
B) "I will recheck your lab reports to make sure that they are correct."
C) "Well, that's just the way it works. You just have to know what the number means."
D) "TSH stands for thyroid stimulating hormone, so if it is low it means that your thyroid is working hard and producing more hormone than it needs to."
Answer: D
Explanation: A) The thyroid is not underactive.
B) The laboratory reports do not need to be rechecked.
C) The nurse should explain what the values mean and not say that the client needs to know what the numbers mean.
D) Explaining to the client the relationship between TSH and thyroid function is the best response to the client who asks about a lab test.
Page Ref: 377
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 8.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Knowledge and Science

5) The nurse is discussing issues related to childbearing with a woman who has a low prolactin level. With which aspect of childbearing should the nurse anticipate the client may have difficulties?
A) Becoming pregnant
B) Staying pregnant
C) Giving birth
D) Breastfeeding
Answer: D
Explanation: A) Prolactin will not impact the client's ability to become pregnant.
B) Prolactin will not impact the client's ability to stay pregnant.
C) Prolactin will not impact the client's ability to give birth.
D) Prolactin is released by the anterior pituitary and enables the client to breastfeed.
Page Ref: 375
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Implementation | Learning Outcome: 8.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Knowledge and Science

6) The nurse is reviewing the endocrine system. Which organ should the nurse identify as the one that influences the release of hormones into the portal circulation?
A) Hypothalamus
B) Pituitary gland
C) Pancreas
D) Adrenal gland
Answer: A
Explanation: A) The hypothalamus is responsible for releasing hormones in the portal circulation.
B) The pituitary gland does not release hormones into the portal circulation.
C) The pancreas does not release hormones into the portal circulation.
D) The adrenal gland does not release hormones into the portal circulation.
Page Ref: 375
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Assessment | Learning Outcome: 8.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

7) A client with acromegaly is scheduled for a growth hormone test. Which action should the nurse take when the client is crying before the test?

A) After the client's growth hormone test has been completed, ask the client why they were crying before the test.

B) Explain to the client that the growth hormone test will not be accurate if performed when the client is emotionally upset, so the test needs to be rescheduled.

C) Wait until the client calms down to have the test performed.

D) Report to the healthcare provider that the client's emotional state must be taken into account when interpreting the growth hormone test.

Answer: B

Explanation: A) The test should not be done if the client is crying.

B) The growth hormone test should be rescheduled because the result will be inaccurate if the client is not fasting or well rested, or is physical or emotionally stressed.

C) The test is going to be inaccurate and should be rescheduled.

D) The test results are going to be inaccurate and should not be done when the client is crying and upset.

Page Ref: 377

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: Nursing Process: Implementation | Learning Outcome: 8.2 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.

NLN Competencies: Knowledge and Science

8) The healthcare provider has ordered a radioactive iodine (RA) uptake exam for a client who has complained of constipation, fatigue, and weight gain. Which information will the nurse include when teaching the client about the test?

A) "This test is used to check all of the endocrine glands that could cause you to have these symptoms."

B) "Your symptoms are related to possible problems with your adrenal gland, so this test will evaluate if this is the problem."

C) "Your symptoms are suggestive of a thyroid problem. Iodine is taken up exclusively by the thyroid gland, so it is used to evaluate if this gland is responsible for your problems."

D) "The pituitary gland puts out iodine that is taken up by the thyroid, so this test will tell if your thyroid is producing enough of this."

Answer: C

Explanation: A) Iodine is not used to check all of the endocrine glands.

B) Iodine is not used to check the adrenal gland.

C) Iodine is taken up by the thyroid, so the RA uptake test is done to see if the thyroid is functioning properly.

D) The pituitary gland does not release iodine.

Page Ref: 378

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: Nursing Process: Implementation | Learning Outcome: 8.2 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: 2.2 Communicate effectively with individuals.

NLN Competencies: Knowledge and Science

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9) The nurse is caring for a client with a large abdomen. Which assessment technique would assist the nurse in determining whether the client is experiencing ascites or the large abdomen is related to obesity?
A) Weigh the client weekly.
B) Check the client's feet for pedal edema.
C) Measure the client's abdomen daily.
D) Measure the amount of food the client eats with each meal.
Answer: C
Explanation: A) Weekly weights would not determine the reason for the client's enlarging abdomen.
B) Pedal edema would not help determine if the enlarging abdomen is caused by ascites or obesity.
C) Frequent measurement of abdominal girth allows the nurse to see if the abdomen is growing quickly, which is seen in ascites but not in obesity.
D) Monitoring the oral intake would not help determine the reason for the client's enlarging abdomen.
Page Ref: 376
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 8.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

10) A client scheduled for a paracentesis is unable to void prior to the procedure. Which action should the nurse take?
A) Request that the healthcare provider (HCP) postpone the procedure until the client can void.
B) Explain to the healthcare provider that extra caution must be taken during the paracentesis because the client couldn't void before the procedure.
C) Ask the healthcare provider for a one-time order for a straight-catheterization.
D) Ask the client to try the void again because the paracentesis cannot be performed until the client's bladder is empty.
Answer: C
Explanation: A) There is no reason to postpone the procedure.
B) The bladder should be emptied before the procedure.
C) Requesting that the HCP order a one-time straight catheterization allows the nurse to empty the client's bladder and the paracentesis to be performed.
D) The client is having difficulty voiding; asking the client to try again would not be appropriate.
Page Ref: 382
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 8.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

11) A client who just had 1,500 mL of fluid removed during a paracentesis asks why the abdomen still feels so big even though that large amount of fluid was removed. Which response should the nurse make?

A) "The skin of your belly stretched while you had fluid in your abdomen and it will take a while for your belly to return to its normal size."

B) "Only a certain amount of fluid can be removed from our abdomen at a time to prevent your body from going into shock."

C) "Removing that much fluid helps to get rid of the excess fluid. Now the rest of the fluid will drain into your lymphatic system."

D) "It was important to limit the amount of fluid that was removed to prevent infection from occurring."

Answer: B

Explanation: A) The abdomen should reduce in size when the fluid is removed and will not take awhile for this to occur.

B) Draining very large amounts of fluid can cause hypovolemia, which could then lead to shock so the amount of fluid drained during a paracentesis is limited to 1,500 mL.

C) The excess abdominal fluid is not drained into the lymphatic system.

D) The removal of fluid is not limited to prevent the development of an infection.

Page Ref: 382

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: Nursing Process: Implementation | Learning Outcome: 8.4 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.

NLN Competencies: Quality & Safety

12) A client with diabetes is not concerned about elevated blood glucose levels because of "feeling fine." Which response should the nurse make?

A) "That's good. I'm glad that nothing has happened to you yet."

B) "Most people with diabetes never develop complications."

C) "I know you say you that you feel fine but you don't know just how sick you are."

D) "While you may feel good right now, complications usually appear after many years of poor glucose control."

Answer: D

Explanation: A) The comment about nothing happening yet is inappropriate.

B) People who have diabetes are at risk for complications.

C) Saying that the client is not aware of how sick they are is inappropriate. The nurse needs to discuss the risk for complications from a high blood glucose level.

D) Informing the client that complications will occur years from now is important to help the client understand why glucose control must be established now.

Page Ref: 385

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: Nursing Process: Implementation | Learning Outcome: 8.5 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: 2.2 Communicate effectively with individuals.

NLN Competencies: Knowledge and Science

13) A client with diabetes mellitus reports dizziness that occurs upon standing. Which complication should the nurse suspect the client is experiencing?
A) Hypertension
B) Impaired peripheral circulation
C) Diabetic autonomic neuropathy
D) Diabetic nephropathy
Answer: C
Explanation: A) The client's symptom is not likely caused by hypertension.
B) The client's symptom is not likely caused by impaired peripheral circulation.
C) Neuropathy caused by diabetes leads to postural hypotension, which causes the client to have dizziness when standing.
D) Diabetic nephropathy would affect urine output.
Page Ref: 386
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 8.5 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

14) A client with newly diagnosed diabetes is concerned about developing renal failure because a parent developed the condition from diabetes. Which response should the nurse make?
A) "It does appear that your disease is progressing quite quickly. Do you have anyone in your family who would donate a kidney for you?"
B) "I wouldn't worry about that right now. Your first job is to get used to having diabetes."
C) "Have you had any other symptoms of kidney failure such as edema or high blood pressure?"
D) "Your current infection was caused by the diabetes, but watching your blood sugar in the future will help prevent complications."
Answer: D
Explanation: A) It would be premature to discuss renal transplant surgery.
B) Care should be focused on preventing long-term complications.
C) The nurse can assess the client for edema and hypertension.
D) The nurse should help the client see the connection between blood glucose control and prevention of complications.
Page Ref: 386
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 8.5 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Knowledge and Science

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15) A client obtaining a capillary blood specimen for glucose actively squeezes the finger after piercing it with a lancet and then places a drop of blood on the test strip. In which way should the nurse interpret the glucose level of 126 mg/dL?
A) The blood sugar is within normal limits for a client with diabetes mellitus.
B) The blood sugar result may be incorrect. The milking of the finger caused the test to read lower than it should.
C) The client should be treated for hypoglycemia because the milking of the finger caused the test to read higher than it should.
D) The client should be instructed to apply pressure to the fingertip when obtaining a capillary blood glucose instead of squeezing the finger.
Answer: B
Explanation: A) The blood glucose level is elevated.
B) The blood sugar reading may be lower than the actual result because of the squeezing or milking of the finger that the client performed after piercing the skin with the lancet.
C) The milking of the finger did not cause the blood glucose level to be higher than it should be.
D) Pressure should not be applied to the fingertip when obtaining a capillary blood sample for a blood glucose level.
Page Ref: 383
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 8.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

16) A client reports not checking blood glucose level frequently because of sore fingers. Which action should the nurse recommend to this client?
A) Push the injector as far into the finger as possible to ensure that an adequate drop is obtained with the first prick.
B) Hang the hand to be used below the waist for a minute to make sure the site that is chosen will have adequate blood supply for the test.
C) For best results, choose the pad of the finger for the test.
D) Allow two or three drops of blood to fall, wipe them away, and then place the next drop of blood on the test strip.
Answer: B
Explanation: A) Pushing the injector further into the finger will not be helpful.
B) Hanging the hand below the waist will increase blood supply to the finger chosen for the blood sample and will make obtaining the correct size blood sample easier for the client.
C) The side of the finger should be used.
D) The second drop of blood should be used with the monitor.
Page Ref: 383
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 8.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

17) Place in correct order the steps for obtaining capillary blood glucose sampling.
A) Cleanse the side of the client's finger.
B) Apply the blood to the test strip.
C) Pierce the skin with a lancet.
D) Calibrate the blood glucose meter.
E) Apply clean gloves.
F) Wipe away the first drop of blood.
Answer: D, A, E, C, F, B
Explanation: A) Cleansing the site is completed after the glucometer is calibrated.
B) Application of blood to the test strip is the last step in capillary blood glucose sampling.
C) Piercing the skin with a lancet is completed after putting on clean gloves.
D) Calibrating the glucometer is the first step in the process to ensure the result is correct.
E) Clean gloves are applied immediately before piercing the skin.
F) The first drop of blood is wiped away before applying the blood to the test strip.
Page Ref: 382-384
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 8.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

18) A client diagnosed with diabetes mellitus has a blood glucose of 275 mg/dl and does not feel well. Which action should the nurse direct the client to take?
A) Obtain a urine specimen and check it for ketones.
B) Immediately go to the emergency department to be admitted.
C) Drink a large beverage that has sugar and electrolytes and recheck the blood sugar.
D) Ask the client if he has a headache or irritability.
Answer: A
Explanation: A) The client has developed hyperglycemia and doesn't feel well, so the nurse should first have the client check the urine for ketones to see if diabetic ketoacidosis is developing.
B) The client does not need to go to the emergency department first.
C) A beverage with sugar should not be ingested.
D) The nurse needs to do more than ask the client if a headache or irritability is present.
Page Ref: 386
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 8.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

19) A client with diabetes is sweating and appears confused. Which action should the nurse take?
A) Check capillary blood glucose level
B) Notify the health care provider
C) Give 4 ounces of orange juice with sugar
D) Prepare a dose of regular insulin as prescribed
Answer: A
Explanation: A) The client is demonstrating signs of a low blood glucose level and the capillary blood glucose should be assessed.
B) The health care provider should not be contacted until the blood glucose level is determined.
C) The blood glucose should be assessed before providing orange juice.
D) Giving a dose of insulin to the client would be inappropriate if the blood glucose level is unknown.
Page Ref: 386
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 8.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

20) The nurse is caring for a client with newly diagnosed diabetes. Which information should the nurse include when teaching the client about the condition? **Select all that apply.**
A) Monitor your blood glucose levels at least once each week.
B) Make sure to take your oral antidiabetic medications as ordered.
C) Exercise at least an hour a day.
D) Make sure that meals and snacks are eaten at regular times.
E) See your healthcare provider (HCP) regularly even if you don't feel ill.
Answer: B, D, E
Explanation: A) Blood glucose level should be checked as prescribed which would be more frequently than once a week.
B) Oral antidiabetic drugs or insulin need to be taken as prescribed to prevent complications.
C) Exercise should be as prescribed by the health care provider. An hour a day may be too strenuous for the client.
D) Food intake should be regulated so that it matches the insulin or oral antidiabetic medications that are taken.
E) It is important for the client to see the HCP regularly to ensure that complications are not developing or to catch early signs of complications.
Page Ref: 386
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Implementation | Learning Outcome: 8.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Knowledge and Science

21) A client with diabetes is wearing a new pair of shoes. For which client statement should the nurse teach the client about foot care?
A) "I am careful to measure the temperature of the water before I get in the bathtub to make sure I don't hurt my feet."
B) "I am so excited about my new shoes. They are a little tight, but the more I wear them the more they will loosen up."
C) "I make sure that my sock don't fit too tightly around my leg."
D) "I am a little worried about cutting my toenails correctly, so I'm going to go to the podiatrist to make sure there is no problem."
Answer: B
Explanation: A) The temperature of water should be checked when taking a bath.
B) The individual with diabetes should not wear shoes that are too tight because it may cause a blister or a sore that will be difficult to heal.
C) Socks should not be tight.
D) A podiatrist should be used for nail care.
Page Ref: 387
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 8.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

Clinical Nursing Skills: A Concept-Based Approach, 4e (Pearson)

Chapter 9 Mobility

1) The nurse observes the unlicensed assistive person (UAP) perform range-of-motion (ROM) exercises to a client's leg. Which observation indicates to the nurse that the UAP is correctly performing abduction of the hip?
A) The UAP moves the leg to the side away from the body.
B) The UAP moves the leg from the side of the body across and in front of the other leg.
C) The UAP bends the knee and brings the heel toward the back of the thigh.
D) The UAP moves the foot down and away from the leg.
Answer: A
Explanation: A) Abduction is the movement of a limb away from the medial plane of the body so abduction of the leg would be movement to the side away from the body.
B) Adduction is moving the leg towards the midline of the body.
C) Bending the knee to the back of the thigh is flexion.
D) Moving the foot down and away from the leg is plantar flexion.
Page Ref: 395
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Implementation | Learning Outcome: 9.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 6.4 Work with other professions to maintain a climate of mutual learning, respect, and shared values.
NLN Competencies: Teamwork

2) The UAP is caring for a 79-year-old client who is immobilized and is preparing to complete range-of-motion (ROM) exercises. Which motion should the nurse caution the UAP to avoid in an older client?
A) Flexion
B) Extension
C) Hyperextension
D) Abduction
Answer: C
Explanation: A) Flexion does not need to be avoided in the older client.
B) Extension does not need to be avoided in the older client.
C) Hyperextension should be avoided in the elderly because joints become less flexible with age and hypertension may cause pain or nerve damage.
D) Abduction does not need to be avoided in the older client.
Page Ref: 396
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Implementation | Learning Outcome: 9.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 6.1 Communicate in a manner that facilitates a partnership approach to quality care delivery.
NLN Competencies: Teamwork

3) The nurse is teaching a group of newly hired UAPs about proper body mechanics. Which equipment should the nurse instruct the UAPs to use?
A) Gait belt
B) Assistive moving device
C) Additional staff
D) No special equipment is required
Answer: D
Explanation: A) A gait belt would be needed to ensure safety and support for body mechanics.
B) An assistive moving device would be needed to ensure safety and support for body mechanics.
C) Additional staff would be needed to ensure safety and support for body mechanics.
D) No special equipment is required to do proper body mechanics but the healthcare worker must know what equipment is available to assist with safe movement of a client.
Page Ref: 391
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 9.1 | QSEN Competencies: Teamwork and Collaboration
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

4) The nurse is observing an unlicensed assistant person (UAP) make an occupied bed. Which correction will the nurse make to ensure body mechanics are being followed?
A) The UAP stands close to the bed while making it.

B) The UAP pulls the client to move him in the bed.
C) The UAP distributes weigh evenly between both feet.
D) The UAP carries the clean sheets and blankets close to the body.
Answer: B
Explanation: A) The UAP should stand close to the bed while making it.
B) Pulling an object (or client) to move it puts a strain on a person's back. The UAP should push to move the object using the legs.
C) The UAP should distribute weight evenly between the feet.
D) The UAP should carry linens close to the body.
Page Ref: 391
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 9.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

5) The charge nurse is making assignments for the staff. Which individual is responsible for ensuring that staff use proper body mechanics in caring for assigned clients?
A) The charge nurse
B) The education director
C) The client's healthcare provider
D) All healthcare personnel
Answer: D
Explanation: A) It is not the charge nurse's responsibility for staff to use proper body mechanics.
B) It is not the educator director's responsibility for staff to use proper body mechanics.
C) It is not the client's healthcare provider's responsibility for staff to use proper body mechanics.
D) All healthcare personnel are responsible for using proper body mechanics when caring for clients.
Page Ref: 390
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Planning | Learning Outcome: 9.1 | QSEN Competencies: Teamwork and Collaboration
AACN Domains and Comps.: 6.2 Perform effectively in different team roles, using principles and values of team dynamics.
NLN Competencies: Teamwork

6) The nurse is performing range of motion (ROM) exercises with a four-year-old child. Which action should the nurse take to meet the child's developmental needs?
A) Explaining why the ROM exercises must be done.
B) Promising the child, a treat after ROM exercises are completed.
C) Turning the ROM exercises into a game.
D) Asking the child's parents to complete the ROM exercises.
Answer: C
Explanation: A) Explaining the purpose of the exercises does not meet the child's developmental needs.
B) The child should not be coerced with a treat to perform the exercises.
C) Turning the ROM exercise experience into a game will meet the child's developmental needs and elicit the most cooperation from the child.
D) It is not the parent's responsibility to complete the exercises.
Page Ref: 395
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Implementation | Learning Outcome: 9.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.5 Develop a plan of care.
NLN Competencies: Relationship Centered Care

7) An older adult client needs to complete range of motion exercises at home. For which reason should the nurse emphasize that these exercises are to be done?
A) Help maintain necessary muscle mass.
B) Prevent the development of depression.
C) Increase dependent behaviors.
D) Support proper body mechanics.
Answer: A
Explanation: A) ROM exercises will help prevent a loss of muscle mass which could lead to difficulties performing activities requiring strength.
B) ROM exercises are not used to prevent depression.
C) ROM exercises are not used to increase dependent behaviors.
D) ROM exercises are not used to support body mechanics.
Page Ref: 396
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Implementation | Learning Outcome: 9.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Knowledge and Science

8) The nurse is observing a UAP assist a client with a vascular problem back into bed. Which position should the nurse remind the UAP to avoid in this client?
A) Low-Fowler
B) Semi-Fowler
C) Orthopneic position
D) Elevate knee-gatch position
Answer: D
Explanation: A) The low-Fowler position does not need to be avoided in this client.
B) The semi-Fowler position does not need to be voided in this client.
C) The orthopneic position does not need to be avoided in this client.
D) The elevate knee-gatch bed position is contraindicated in clients with vascular problems because it will put pressure on the blood vessels at the back of the knee.
Page Ref: 405
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 9.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

9) The nurse is preparing to place a client with COPD in the orthopneic bed position. Which item should the nurse place in front of the client to maintain this position?
A) Wheelchair
B) Stationary chair
C) Over the bed table
D) Client's urinal
Answer: C
Explanation: A) A wheelchair will not help the client remain in the orthopneic position.
B) A stationary chair will not help the client remain in the orthopneic position.
C) An overbed table is necessary when the client is in the orthopneic position because it assists the client with exhalation.
D) A urinal will not help the client maintain in the orthopneic position.
Page Ref: 405
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Implementation | Learning Outcome: 9.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

10) The nurse is caring for a client who is complaining of esophageal reflux symptoms. After administering the prescribed medication, the nurse will place the client in which bed position to assist in providing comfort to this client?
A) Semi-Fowler

B) Reverse Trendelenburg
C) Trendelenburg
D) High-Fowler
Answer: B
Explanation: A) The semi-Fowler position will not help keep the gastric contents out of the esophagus.
B) Reverse Trendelenburg places the client in position with the bed tilted down starting at the foot of the bed so the entire bed is tilted down. This allows gravity to assist with keeping gastric contents in the stomach and out of the esophagus.
C) The Trendelenburg position will encourage gastric contents to move into the esophagus.
D) The high-Fowler position is not ideal to prevent gastric contents from moving into the esophagus.
Page Ref: 406
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Implementation | Learning Outcome: 9.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

11) The nurse and the UAP are preparing to logroll a client who has a spinal injury. The nurse will ask the UAP to obtain which assistive device prior to beginning the procedure?
A) Trochanter roll
B) Hydraulic lift
C) Friction-reducing device
D) Foot board
Answer: C
Explanation: A) A trochanter roll will not help with logrolling a client.
B) A hydraulic lift is not used to logroll a client.
C) A friction-reducing device is necessary to pull the client to the side of the bed prior to logrolling the client.
D) A foot board will not help with logrolling a client.
Page Ref: 401
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Planning | Learning Outcome: 9.4 | QSEN Competencies: Client-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

12) The nurse is caring for a client with limited movement who weighs 415 pounds. Which assistive device should the nurse use to move this client up in bed?
A) Mechanical lift
B) Turn sheet
C) Fiction-reducing device
D) Pull sheet
Answer: A
Explanation: A) A mechanical lift is necessary to move an obese client up in the bed because the client's weight and immobility will require the nurse to lift more than 35 pounds of the client's weight.
B) The nurse will need to use more than a turn sheet to move the client up in bed.
C) The nurse will need more than a friction-reducing device to move the client up in bed.
D) The nurse will need more than a pull sheet to move the client up in bed.
Page Ref: 392, 402
Cognitive Level: Applying
Client Need/Sub: Management of Care: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 9.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

13) The nurse and the UAP are preparing to move a client from the bed to a chair for the first time using a hydraulic lift. What is the first thing the nurse should do prior to beginning this procedure?
A) Place the canvas sling under the client's thighs.
B) Place the client in the supine position.
C) Lock the wheels of the client's bed.
D) Demonstrate the use of the hydraulic lift to the client.
Answer: D
Explanation: A) Placing the sling under the client's thighs will be done after the client understands how the lift will be used.
B) Placing the client in the supine position will be done after the client understands how the lift will be used.
C) Locking the wheels of the client's bed will be done after the client understands how the lift will be used.
D) Prior to using the hydraulic lift with a client for the first time, the nurse should demonstrate the use of the lift to calm any anxieties the client may have about the lift.
Page Ref: 399
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Implementation | Learning Outcome: 9.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Knowledge and Science

14) The nurse is caring for a client who uses a hydraulic lift to be moved out of the bed. Which action should the nurse take before starting this procedure?
A) Perform hand hygiene.
B) Request help from another staff member.
C) Roll the client to the side to position the sling.
D) Demonstrate the use of the hydraulic lift to the client.
Answer: B
Explanation: A) Hand hygiene can be completed after assistance is obtained.
B) A minimum of 2 healthcare workers is required to safely move a client with a hydraulic lift. The nurse should first obtain assistance.
C) Rolling the client to the side to position the sling is a part of the process of using the sling and is not done before lift is used.
D) After assistance is obtained, demonstrating the use of the hydraulic lift to the client can be done.
Page Ref: 399
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 9.5 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

15) The nurse is preparing to assist a client with ambulation. For which reason should a gait belt be inappropriate for a client?
A) Wears a knee brace.
B) Uses a walker for ambulation.
C) Has a large abdominal incision.
D) Has vertigo.
Answer: C
Explanation: A) A gait belt can be safely used for a patient wearing a knee brace.
B) A gait belt may not be appropriate for a client who has an abdominal incision because of the pressure it may put on the incision.
C) A gait belt can be safely used with a walker.
D) A gait belt can be safely used with a client who has vertigo.
Page Ref: 398
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 9.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

16) The nurse is watching an unlicensed assistive person (UAP) prepare to move an eighteen-month-old toddler from the pediatric unit to the radiology unit. The nurse will stop the UAP if the UAP chooses which form of transport?
A) The child's crib
B) Pediatric wheelchair
C) Walking while holding the mother's hand
D) Stretcher
Answer: D
Explanation: A) A toddler can be transferred safely in a crib.
B) A toddler can be transferred safely in a pediatric wheelchair.
C) A toddler can be transported safety by walking and holding the mother's hand.
D) A stretcher is not a safe form of transport because a mobile toddler could possibly fall off of it.
Page Ref: 414
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 9.6 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

17) The nurse is preparing to transport a six-month-old infant to the radiology department. Which measures will the nurse institute to safely complete this procedure? **Select all that apply.**
A) Ensure the parents stay in the infant's room.
B) Unhook all monitors and IV lines prior to transporting the infant.
C) Use a high-top crib for transporting.
D) Cover the infant with a blanket.
E) Ensure the infant's hands are washed before transport begins.
Answer: C, D
Explanation: A) There is no reason for the parents to stay in the infant's room.
B) The monitors and IV lines can be transported with the infant
C) A high-top crib ensures the infant can't fall during transport.
D) Infant is kept covered to prevent hypothermia from occurring.
E) Hand hygiene of the infant is not essential before transporting.
Page Ref: 414
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 9.6 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

18) The nurse is preparing to ambulate a client with crutches. In which area should the nurse stand when assisting the client?
A) On the client's affected side and slightly behind.

B) On the client's strong side and slightly ahead.
C) On the client's affected side and directly next to the client.
D) On the client's strong side and directly next to the client.
Answer: A
Explanation: A) The nurse stands behind the client and toward the affected side to provide support if the client loses balance.
B) The nurse should not stand on the strong side or slightly ahead of the client.
C) The nurse should not stand directly next to the client.
D) The nurse should not stand on the strong side and directly next to the client.
Page Ref: 418
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 9.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

19) The nurse is aware that which client would BEST be able to handle a three-point gait using crutches?
A) A 76-year-old client who complains of pain in both knees.
B) A 25-year-old client with a broken right ankle.
C) A 19-year-old client with a broken right tibia and a sprained left foot.
D) A 55-year-old client with a fractured left patella and a right foot laceration.
Answer: B
Explanation: A) A client with bilateral knee pain would not be able to safely ambulate using the three-point gain on crutches.
B) The three-point gait requires that the client must bear the entire body weight on the unaffected leg. A young person whose only injury is a broken right ankle would be able to do this.
C) A client with injuries to a leg and a foot would not be able to safely ambulate using the three-point gait on crutches.
D) A client with injuries to a knee and a foot would not be able to safely ambulate using the three-point gait on crutches.
Page Ref: 419
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Assessment | Learning Outcome: 9.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

20) A client uses the swing-to-gait on crutches to ambulate. Which problem should the nurse be aware that can develop?
A) Atrophy of the arm muscles
B) Fractures of the feet
C) Atrophy of the leg muscles
D) Sciatic nerve injury
Answer: C
Explanation: A) The swing-to-gait will not cause atrophy of the arm muscles.
B) The sing-to-gait will not cause foot fractures.
C) Prolonged use of the swing-to-gait can cause atrophy of unused muscles, the legs.
D) The swing-to-gait will not cause sciatic nerve injury.
Page Ref: 420
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Evaluation | Learning Outcome: 9.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.7 Evaluate outcomes of care.
NLN Competencies: Knowledge and Science

21) The nurse is caring for a client who was placed in skeletal traction 48 hours ago for treatment of a serious femur fracture. At which time interval will the nurse check the client's neurovascular status of the affected foot?
A) Every 30 minutes
B) Every 1 hour
C) Every 4 hours
D) Every 24 hours
Answer: C
Explanation: A) The neurovascular status of the affected extremity every 30 min initially.
B) The neurovascular status is checked every 1–2 hr for the first 24 hr.
C) The client's neurovascular status is checked every 4 hours while the client remains in traction.
D) The neurovascular status is assessed more frequently than every 24 hours.
Page Ref: 431
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 9.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

22) The nurse is preparing to conduct an hourly assessment of a client who was placed in skin traction approximately 6 hours ago and has been stable since that time. The plan is to check the client's vital signs, pain level and complete which other assessments? **Select all that apply.**
A) Neurovascular assessment of the unaffected leg.

B) Skin integrity of both heels.
C) Massage the skin of the buttocks with a dry washcloth.
D) Ensure traction weight is correctly placed.
E) Ensure client's shoulders and hips are in alignment.
Answer: B, D, E
Explanation: A) The unaffected leg does not need neurovascular assessments.
B) Check the skin integrity of any area exposed to the surface of the bed like the heels.
C) The skin should not be massed with a dry washcloth.
D) The nurse should ensure that the weights are hanging properly, not sitting on the floor.
E) The body alignment shoulders and hips in alignment) should be checked often.
Page Ref: 431
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 9.8 | QSEN Competencies: Safety
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

23) Unlicensed assistive person (UAP) is providing personal care to a client in skin traction. In which position should the client be placed for this care?

A) Semi-Fowler
B) Low-Fowler
C) Lateral
D) Supine

Answer: D

Explanation: A) The client should not be placed in the semi-Fowler position.
B) The client should not be placed in the low-Fowler position.
C) The client should not be placed in the lateral position.
D) The client in skin traction must be maintained in the supine position to maintain body alignment and proper traction.

Page Ref: 430
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 9.8 | QSEN Competencies: Safety
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

24) The nurse is preparing to do pin site care for a client in skeletal traction. It is noted that the site appears red and feels warm to the touch. Which action will the nurse perform in taking care of this situation? **Select all that apply.**

A) Notify the healthcare provider.
B) Refrain from disturbing the crusts around the pin until the healthcare provider can observe it.
C) Expect to obtain a culture and sensitivity specimen from the pin site.
D) Remove the client's traction weights until the healthcare provider sees the client.
E) Check the client's vital signs.

Answer: A, C, E

Explanation: A) The healthcare provider should be notified immediately once an infection is suspected.
B) The crusts should be removed from around the pins.
C) A culture and sensitivity of the drainage is obtained so antibiotic sensitivity can be determined.
D) The weights should not be removed.
E) The nurse should take the client's temperature to monitor for signs of systemic infection.

Page Ref: 432
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 9.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

***Clinical Nursing Skills: A Concept-Based Approach, 4e* (Pearson)**
Chapter 10 Nutrition

1) The nurse is teaching about nutritional requirements of the newborn to his new parents. The nurse should recognize that the parents need further instruction when which statement is made?
A) "I will only feed my baby as much formula as he wants to eat at each feeding."
B) "I will mix rice cereal in my baby's bottle before he goes to bed so he will sleep better."
C) "I will hold my baby while I feed him and for about 15 minutes after he eats."
D) "I will wash my hands before I mix my baby's formula."
Answer: B
Explanation: A) The baby should be fed according to infant cues and not the clock.
B) Solid foods including rice cereal shouldn't be introduced until the baby is at least 6 months old.
C) The baby should be held during and after a feeding.
D) Hand hygiene should be done before mixing formula.
Page Ref: 441
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 10.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

2) The nurse is teaching a group of toddler parents about snack foods that are safe for this age group and should include which food in this teaching?
A) Grapes
B) Popcorn
C) Corn chips
D) Applesauce
Answer: D
Explanation: A) Grapes are a choking hazard.
B) Popcorn is a choking hazard.
C) Corn chips are a choking hazard.
D) Applesauce is safe because it is easily swallowed and is not a choking hazard. Grapes, popcorn, and chips can all cause choking.
Page Ref: 442
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Implementation | Learning Outcome: 10.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Knowledge and Science

WwW. TeSt-Wg

3) The nurse is working with a group of parents of toddlers and should know that further instruction is needed when which statement is heard?
A) "I carefully cut up all of my child's food so he can easily eat it."
B) "I put food on my toddler's plate but I don't get upset if he doesn't eat it all."
C) "I promise my toddler that he can have a cookie if he does what I ask him to do."
D) "I allow my child to help me cook even though it gets pretty messy."
Answer: C
Explanation: A) Food should be cut up for a toddler.
B) A toddler will eat what they want and should not be forced to eat it all.
C) Food should never be used as a bribe.
D) The child should be involved in snack preparation.
Page Ref: 442
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Evaluation | Learning Outcome: 10.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 2.7 Evaluate outcomes of care.
NLN Competencies: Knowledge and Science

4) The nurse knows that which setting would be most effective in assisting adolescents to eat a more nutritious diet?
A) In a small group of their peers
B) At the hospital cafeteria
C) At a table with parents
D) Served to each teenager privately
Answer: A
Explanation: A) Adolescents are influenced the most by their own peer group.
B) Eating at a cafeteria will not encourage the adolescent to eat a more nutritious diet.
C) Eating with parents will not encourage the adolescent to eat a more nutritious diet.
D) Eating alone does not help an adolescent eat a more nutrition diet.
Page Ref: 442
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Planning | Learning Outcome: 10.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 2.5 Develop a plan of care.
NLN Competencies: Knowledge and Science

5) The nurse is performing a nutritional assessment of an older adult client who has reported a 10-pound weight loss in the last 6 weeks with no history of dieting. If no disease process is found, the nurse is aware that weight loss can result from what issue for this age group?
A) Attends a daily meal program for senior citizens.
B) Appears to have loose, ill-fitting dentures.
C) Lives with a daughter who fixes dinner every night.
D) Has a regular elimination schedule.
Answer: B
Explanation: A) Attending a daily meal program would not cause an older client to have an unexplained weight loss.
B) Loose or ill-fitting dentures may cause the client to avoid chewing foods, which can lead to decreased intake and weight loss.
C) Living with family would not cause an older client to have an unexplained weight loss.
D) Having a regular elimination schedule would not cause an older client to have an unexplained weight loss.
Page Ref: 444
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Assessment | Learning Outcome: 10.2 | QSEN Competencies: Client-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

6) The nurse is caring for a client who is in the midst of a 24-hour urine collection for urinary nitrogen and would know which test will help determine if the client has an adequate intake of what nutrient?
A) Carbohydrates
B) Fats
C) Proteins
D) Sugars
Answer: C
Explanation: A) A 24-hour urine for nitrogen is not used to measure the intake of carbohydrates.
B) A 24-hour urine for nitrogen is not used to measure the intake of fats.
C) The 24-hour urinary nitrogen test is done to measure inadequate protein intake.
D) A 24-hour urine test for nitrogen is not used to measure the intake of sugars.
Page Ref: 447
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 10.2 | QSEN Competencies: Client-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

7) The nurse is completing an anthropometric measurement of an individual and should use which instruments to complete this assessment?
A) Yard stick and scale
B) Yard stick and tape measure
C) Tape measure and ruler
D) Tape measure and skinfold caliper
Answer: D
Explanation: A) A yard stick is not used for anthropometric measurements.
B) A yard stick is not used for anthropometric measurements.
C) A ruler is not used for anthropometric measurements.
D) Anthropometric measurements require a tape measure to measure circumference of the upper arm and a skinfold caliper to measure skinfold thickness of the triceps muscle.

Page Ref: 446
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 10.2 | QSEN Competencies: Client-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

8) The nurse is completing an admission assessment of a bedridden client and will use which technique to measure the height of this client?
A) Place the client in a bed sling and use a tape measure to measure the client's length.
B) Ask the client to fully extend both arms out to the sides of the body and measure the arm span.
C) Assist the client to a sitting position and measure the length of the client's spine and double the number.
D) Using a tape measure, measure around the client's fist and multiply by 5.
Answer: B
Explanation: A) Height is not measured by placing the client in a bed sling.
B) The best way to estimate height in a bedridden client is to measure the client's arm span.
C) A client's height in more measured by measuring the length of the spine and doubling the length.
D) The client's fist is not the approach used to measure the height of a bedridden client.
Page Ref: 446
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Assessment | Learning Outcome: 10.2 | QSEN Competencies: Client-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

WwW.TeSm.Ws

9) The nurse is working with a group of parents who have children that are extremely picky eaters and tells them that which makes the biggest impact on a child's lifetime eating habits?
A) Peer groups as teenagers
B) Being breastfed as an infant
C) Habits learned as a young child
D) Lessons on nutrition taught in middle school
Answer: C
Explanation: A) Lifetime eating habits are not influenced by peers.
B) Lifetime eating habits are not influenced by being breastfed as an infant.
C) The biggest impact on a child's lifetime eating habits are the habits learned as a young child.
D) Lifetime eating habits are not influenced by lessons about nutrition taught during middle school.
Page Ref: 442
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 10.3 | QSEN Competencies: Client-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Knowledge and Science

10) The nurse is assisting a client with swallowing difficulties to eat. Which portion of food should the nurse instruct the client to take for each bite?
A) Negligible amount
B) Large enough to require chewing
C) A large full bite
D) As much as the client wants
Answer: B
Explanation: A) A negligible amount is not large enough as a bite.
B) The client should be instructed to take a bite that is large enough for chewing.
C) A large full bite would not be a safe amount for a client with swallowing difficulties.
D) As much food as the client wants would not be a safe amount for the client with swallowing difficulties.
Page Ref: 443
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Implementation | Learning Outcome: 10.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

11) The nurse observes a client with dysphagia who is eating and should discourage which activity?
A) Using a straw
B) Using a spoon to eat a milkshake
C) Using a towel under the plate
D) Sitting at a 90-degree angle in bed
Answer: A
Explanation: A) The use of a straw increases the risk of aspiration and should be discouraged.
B) A spoon can be used to eat.
C) A towel should be placed under the plate.
D) Sitting at a 90-degree angle is an appropriate position.
Page Ref: 444
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 10.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

12) The nurse is feeding a client with dementia and should assist swallowing with which nursing action?
A) Encourage the client to drink water between each bite.
B) Stroke the client in a downward motion under the chin.
C) Blow softly in the client's face to encourage swallowing.
D) Tell the client to quickly take bites to facilitate swallowing.

Answer: B
Explanation: A) Drinking water between bites will not help with swallowing.
B) Gently stroking the client under the chin in a downward motion during swallowing helps to cue the client to swallow.
C) Blowing in the client's face will not help with swallowing.
D) Instructing to take frequent bites will not help with swallowing.
Page Ref: 443
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 10.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

13) The nurse has just finished inserting a nasogastric tube into a client that will be used for enteral feeding and knows that prior to starting the feeding, tube placement will BEST be confirmed using which method?
A) Determining the presence of carbon dioxide
B) Ensuring that the gastric aspirate has a pH higher than 7
C) Obtaining an x-ray to confirm placement
D) Inserting 30 mL of air into the tube and listening over the stomach for the whoosh
Answer: C
Explanation: A) Carbon dioxide would be used to detect if the tube is in the lungs.
B) A pH higher than 7 indicates the tube is lower in the gastrointestinal tract or in the lungs.
C) An x-ray is the best way to confirm tube placement because all nasogastric tubes are marked to be seen on x-ray.
D) Inserting air through the tube and listening for a sound is not a valid way to assess for nasogastric tube placement.
Page Ref: 462
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 10.5 | QSEN Competencies: Evidence-Based Practice
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

14) The nurse is caring for a client who will be receiving continuous enteral feeding through a nasogastric feeding tube. The nurse is aware that which is the most dangerous complication associated with improper nasogastric tube placement?

A) Diarrhea
B) Vomiting
C) Pneumonia
D) Dehydration
Answer: C
Explanation: A) Diarrhea would not be caused by an improperly placed nasogastric tube.
B) Vomiting could indicate that the tube is blocked.
C) Aspiration pneumonia is by far the most dangerous complication associated with feeding a client when the feeding tube is improperly placed.
D) Dehydration would indicate that the client is not getting sufficient fluid or is experiencing severe diarrhea from the solution.
Page Ref: 470
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 10.5 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

15) The nurse has just completed insertion of a nasogastric tube that is needed for gastric lavage of a client. Radiographic confirmation of placement is not possible at this time, so the nurse should use which method to best determine tube placement?
A) Aspirate gastric contents and determine the bilirubin level.
B) Observe for signs of respiratory distress.
C) Determine that the pH of the gastric aspirate is below 4.
D) Detect for carbon dioxide and determine the gastric pH.
Answer: D
Explanation: A) Aspirating gastric contents to determine the bilirubin level is not as effective to ensure the tube is properly positioned.
B) Signs of respiratory distress is not an appropriate strategy to assess for nasogastric tube placement.
C) Something else should be done in addition to checking the pH of gastric contents.
D) If an x-ray confirmation is not available, the nurse should use two different methods such as lack of respiratory distress and acid gastric aspirate.
Page Ref: 461
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 10.5 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Knowledge and Science

16) The nurse is preparing to insert a nasogastric tube into a newborn and plans to use which landmark to ensure that the tube reaches into the infant's stomach?
A) The tip of the xiphoid process
B) Midway between the nipples
C) Midway between the xiphoid and the umbilicus
D) The top of the symphysis pubis
Answer: C
Explanation: A) The tip of the xiphoid process is too far.
B) Midway between the nipples is not advanced enough.
C) In a newborn, the length of the NG tube is measured from the nose to the tip of the earlobe to a point midway between the umbilicus and the xiphoid process.
D) The top of the symphysis pubis is too far.
Page Ref: 463
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 10.5 | QSEN Competencies: Evidence-Based Practice
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

17) The nurse is caring for a client receiving enteral nutrition through a syringe. Midway through the feeding, the client complains of gas pains. Which is the nurse's BEST action at this time?
A) Contact the healthcare provider.
B) Clamp the tubing going to the client for a short time to see if symptoms are relieved.
C) Stop the feeding and remove the nasogastric tube.
D) Continue the feeding while reassuring the client that this is a common issue related to enteral feedings.
Answer: B
Explanation: A) The healthcare provider does not need to be contacted.
B) If a client complains of flatus, cramps, or vomiting during a syringe feeding, the nurse should pinch or clamp the tubing to stop the flow for a minute.
C) The feeding does not need to be stopped. The nasogastric tube does not need to be removed.
D) The feeding should not be continued as this will cause the client more discomfort.
Page Ref: 456
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 10.6 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

18) The nurse has just begun a new enteral feeding on a client using a closed system of formula. The nurse labels the bag with the time and date it was begun (1300 hours on 12/6) knowing that this will mean the feeding tubing set will need to be changed at which time and date?

A) 1300 hours on 12/7
B) 0100 hours on 12/7
C) 1300 hours on 12/8
D) 1300 hours on 12/9
Answer: A
Explanation: A) Whether using a closed or an open system, the feeding tubing set is usually changed every 24 hours to reduce the risk of contamination.
B) The feeding tube set does not need to be changed in 8 hours.
C) The set needs to be changed before 48 hours.
D) The set needs to be changed before 72 hours.
Page Ref: 457
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 10.6 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

19) The nurse is caring for a client receiving total parenteral nutrition (TPN) and will instruct the unlicensed assistive person (UAP) to complete which assessment every 4 hours?
A) Blood pressure
B) Pulse
C) Temperature
D) Pain level
Answer: C
Explanation: A) Blood pressure does not need to be assessed every 4 hours because of receiving TPN.
B) Pulse does not need to be assessed every 4 hours because of receiving TPN.
C) The client receiving TPN is at a high risk for infection, so temperature assessment should be completed at least every 4 hours.
D) The nurse is responsible for assessing pain level.
Page Ref: 469
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 10.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

20) The nurse started a lipid infusion on a client approximately 1 hour ago and will observe for which signs and symptoms related to lipid side effects? **Select all that apply.**
A) Dizziness
B) Peripheral neuropathy
C) Nausea
D) Joint pain
E) Headache
F) Insomnia
Answer: A, C, E
Explanation: A) Dizziness is an IV lipid side effect.
B) Peripheral neuropathy is not a side effect of IV lipids.
C) Nausea and vomiting are known IV lipid side effects.
D) Joint pain is not a side effect of IV lipids.
E) Headache is a known IV lipid side effect.
F) Insomnia is not a side effect of IV lipids.
Page Ref: 466
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Assessment | Learning Outcome: 10.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

21) The nurse is preparing to infuse intravenous lipids on a client and should utilize which safety considerations when completing this action? **Select all that apply.**
A) Perform hand hygiene prior to touching any of the equipment.
B) Swab the stopper of the IV bottle with alcohol and immediately spike the bottle.
C) Hang the IV bottle of lipids approximately 18 inches above the IV site.
D) Piggyback the lipids into the port closest to the client.
E) Set the pump for 100 mL/hour.
Answer: A, D
Explanation: A) Hand hygiene should always be performed prior to beginning any procedure. In addition, the nurse will wear clean gloves when hanging the infusion.
B) The access port should be permitted to dry before spiking the container.
C) Intralipids do not need to be hung 18 inches above the IV site.
D) The lipids should be piggybacked into the port closest to the client.
E) The pump should be set according to the healthcare provider's orders.
Page Ref: 466-467
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Implementation | Learning Outcome: 10.8 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

***Clinical Nursing Skills: A Concept-Based Approach, 4e* (Pearson)**
Chapter 11 Oxygenation

1) The nurse has been asked to obtain a sputum specimen from a client who is in the first postoperative day after a surgical gastric resection for stomach cancer. The nurse will ensure that which item is provided to the client to ensure an effective sputum collection?
A) Supplemental oxygen
B) Folded bath blanket
C) Peak expiratory flow meter
D) Sterile applicator stick
Answer: B
Explanation: A) Supplemental oxygen will not help the client provide a sputum specimen.
B) A folded bath blanket will be used by the client to hold against the abdomen to allow for effective coughing.
C) A peak expiratory flow meter will not help the client provide a sputum specimen.
D) A sterile applicator stick will not help the client provide a sputum specimen.
Page Ref: 478
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Implementation | Learning Outcome: 11.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

2) After completing instructions for collecting a sputum specimen to the client, the nurse observes the client remove the lid of the specimen container and spit into the cup. Which is the nurse's next best action?
A) Ask the client if the specimen obtained was sputum or saliva.
B) Explain to the client that the specimen will have to be obtained by suctioning.
C) Provide the client with a new specimen container and explain again how to obtain the specimen.
D) Send the specimen to the lab as obtained but label it as saliva.
Answer: C
Explanation: A) The client provided saliva and not sputum.
B) Suctioning is not required.
C) The nurse should explain again how to obtain the specimen and give the client a new specimen container.
D) Saliva is not appropriate for a sputum specimen.
Page Ref: 478
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 11.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

3) The nurse is assisting a client in obtaining a sputum specimen. After a deep cough, the client produces approximately 1/2 tsp of sputum. Which is the nurse's next action?
A) Assist the client to cough again and produce more sputum.
B) Send the specimen to the lab.
C) Allow the client to rest for one hour and then ask the client to cough again.
D) Ask the client to walk around for 30 minutes and try again to produce sputum.
Answer: A
Explanation: A) A sputum specimen requires 1-2 tsp of sputum, so the nurse should assist the client to repeat the coughing to produce additional sputum.
B) The client needs to provide more sputum.
C) The specimen should not be held for an hour.
D) The client does not need to walk around before attempting to provide more sputum for the specimen.
Page Ref: 478
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 11.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

4) The nurse is preparing to assist a client in obtaining a sputum specimen and should place the client in which position?
A) Low Fowler
B) Side-lying
C) Semi-Fowler
D) Trendelenburg
Answer: C
Explanation: A) The low-Fowler position will not help the client provide a sputum specimen.
B) The side-lying position will not help the client provide a sputum specimen.
C) Semi-Fowler position allows for maximum lung ventilation and expansion. Other positions that would be effective would be high Fowler, or sitting on the side of a bed or in a chair.
D) The Trendelenburg position will not help the client provide a sputum specimen.
Page Ref: 478
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 11.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

5) The nurse should encourage the client to use incentive spirometry prior to which procedure?
A) Ambulating the client
B) Preparing the client for a rest period
C) Removing the client's meal tray
D) Obtaining a sputum specimen
Answer: D
Explanation: A) Incentive spirometry is not needed before ambulation.
B) Incentive spirometry is not needed before resting.
C) Incentive spirometry is not needed before removing a meal try.
D) The deep breathing that is completed with incentive spirometry may help a client prepare for obtaining a sputum specimen.
Page Ref: 478
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 11.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

6) The nurse observes a client using the incentive spirometer and determines that further instruction is required when the client performs which action?
A) Exhales before placing the incentive spirometer to the lips
B) Seals the lips tightly around the mouthpiece of the incentive spirometer
C) Inhales quickly, causing the spirometer balls to snap to the top of the incentive spirometer
D) Attempts to cough productively after using the incentive spirometer
Answer: C
Explanation: A) The client should exhale before placing the device in the mouth.
B) The lips should be sealed tightly around the mouthpiece.
C) The client should inhale slowly, not quickly, and deeply to ensure maximal lung expansion.
D) The client should cough productively after using the device.
Page Ref: 481
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Evaluation | Learning Outcome: 11.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

WwW.TeSm.Ws

7) The nurse should know that which action is needed to assist the client to effectively use a volume-oriented incentive spirometer?
A) The spirometer must be held in an upright position.
B) A nose clip must be used for effective inhalation.
C) The procedure must be repeated every 15 minutes to be effective.
D) Clean the spirometer in the dishwasher when used at home.
Answer: A
Explanation: A) A volume-oriented incentive spirometer must be used in an upright position to function correctly.
B) A nose clip is not needed for an adult.
C) The procedure does not need to be repeated every 15 minutes.
D) The device is not cleansed in the dishwasher at home.
Page Ref: 481
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 10.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

8) The nurse is caring for a 4-year-old postoperative client who has been unable to understand the use of the incentive spirometer. The nurse should choose which activity that will assist the child to perform the same action as the spirometer?
A) Blowing out candles
B) Sucking on a straw
C) Filling up a balloon
D) Using bubbles
Answer: B
Explanation: A) The use of an incentive spirometer does not focus on exhalation. Blowing out a candle uses exhalation.
B) Incentive spirometry focuses on inhalation, which is the action that sucking on a straw will imitate.
C) Filling up a balloon uses exhalation.
D) Using bubbles uses exhalation.
Page Ref: 482
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 11.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

9) The nurse is caring for a client with chronic obstructive pulmonary disease (COPD) who is receiving supplemental oxygen. Which delivery system should the nurse question being used for this client?

A) Nasal cannula
B) Continuous positive airway pressure (CPAP)
C) Bilevel positive airway pressure (BiPAP)
D) Venturi face mask

Answer: D

Explanation: A) Nasal cannula would be appropriate for the client.
B) CPAP would be appropriate for the client with COPD.
C) BiPAP would be appropriate for the client with COPD.
D) A Venturi face mask provides oxygen concentrations from 24% to 50% with flow rates from 4-10 L/min, which would be too high for a client with COPD and may cause the client's breathing stimuli to be suppressed.

Page Ref: 488
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 11.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

10) The nurse is caring for a group of clients with respiratory disorders and should know that which client should not be placed on continuous positive airway pressure (CPAP) to assist with respiratory distress?

WwW.TeSt.Wg

A) The client with chronic obstructive pulmonary disease (COPD) who is complaining of shortness of breath
B) The client whose respirations have fallen to 8/minute after receiving morphine sulfate
C) The client who experiences apnea during sleep
D) The client who is experiencing wheezing and is having difficulty moving air adequately

Answer: B

Explanation: A) CPAP can be safely used for a client with COPD.
B) CPAP should never be used on clients receiving opioids because it causes the pharynx to relax and contributes to further airway obstruction.
C) CPAP can be safely used for a client with apnea.
D) CPAP can be safely used for a client experiencing wheezing.

Page Ref: 489
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 11.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

11) The nurse is caring for a client who was just placed on supplemental oxygen per nasal cannula and should contact the healthcare provider if which assessment data are noted at the next assessment? **Select all that apply.**
A) The client complains of feeling anxious and restless.
B) Skin color is pink and warm to touch.
C) The heart rate is 82.
D) The respiratory rate is 36.
E) The client is using accessory muscles to breathe.
Answer: A, D, E
Explanation: A) Feelings of anxiety and restlessness are signs of hypoxia and should be reported.
B) Skin color that is pink and warm to touch is an expected outcome.
C) A heart rate of 82 is within normal limits.
D) A respiratory rate of 36 indicates the client is breathing abnormally fast and it should be reported.
E) The use of accessory muscles to breathe indicates difficulty breathing and should be reported.
Page Ref: 490
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 11.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

12) The nurse is caring for a client who is exhibiting severe respiratory distress and is receiving supplemental oxygen through a nonrebreather mask. While assessing the client, the nurse notes that the bag attached to the mask is deflated. Which is the nurse's BEST action?
A) Document it as functioning normally.
B) Decrease the flow of oxygen to the mask.
C) Increase the flow of oxygen to the mask.
D) Prepare for endotracheal intubation.
Answer: C
Explanation: A) The device is not functioning as expected.
B) The flow of oxygen should not be decreased.
C) If the bag is completely deflated, the nurse should increase the flow of oxygen to the mask and then contact the healthcare provider.
D) The client does not need intubated.
Page Ref: 488
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 11.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

13) The nurse is caring for a client with pneumonia and should be most concerned about which assessment?
A) The client cannot remember which day it is.
B) The client's heart rate has risen from 72 to 78 bpm.
C) The client's pulse oximetry has decreased from 99% to 97%.
D) The client respiratory rate has risen from 16 to 20 breaths per minute.
Answer: A
Explanation: A) One of the early signs of hypoxia is confusion and should be reported immediately.
B) A change in heart rate of 6 beats is still within normal limits.
C) A drop of 2% in oxygen is still within normal limits.
D) An increase in respiratory rate is still within normal limits.
Page Ref: 490
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 11.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

14) The nurse is caring for a client with a respiratory disorder and should alert the healthcare provider if the client displays which signs or symptoms that indicate early hypoxia? **Select all that apply.**

A) Headache
B) Nausea
C) Heart rate of 52
D) Respiratory rate of 30
E) Blurred vision
F) Hemoglobin of 17.3 mg/dl
Answer: A, D, E
Explanation: A) Headache is an early sign of hypoxia.
B) Nausea is not a sign of hypoxia.
C) Bradycardia is not a sign of hypoxia.
D) Tachypnea is an early sign of hypoxia.
E) Visual disturbances are an early sign of hypoxia.
F) A hemoglobin level of 17.3 mg/dL is not a sign of hypoxia.
Page Ref: 490
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 11.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

15) The nurse has just completed insertion of a nasal trumpet to assist in protecting a responsive client's airway and should place the client in which position to maintain the airway?
A) Supine with the head to the side
B) Side-lying with chin positioned closest to the chest
C) Prone with head to the side
D) Side-lying with head slightly tilted up and centered on the pillow
Answer: D
Explanation: A) Supine position would not be appropriate to maintain the airway and allow for drainage of secretions.
B) The chin should not be bent forward.
C) The prone position would not maintain the airway and permit secretions to drain.
D) The client should be positioned in a side-lying position with the head slightly tilted up to maintain and open airway and to allow for adequate drainage of secretions.
Page Ref: 496
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 11.5 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

16) The nurse is preparing to insert an oropharyngeal airway in an unresponsive client and should do which to ensure the airway is inserted correctly?
A) Using a tongue depressor, push the tongue to the side of the mouth when inserting the airway.
B) Begin the procedure by inserting the airway upside down and then rotating it to the correct position.
C) Position the airway in a downward position and then rotate it upward as it passes by the back of the throat.
D) Refrain from taping the bottom of the airway to prevent esophageal injury when the client swallows.

Answer: B
Explanation: A) The tongue is not pushed to the side.
B) The procedure is begun with the airway curved upward (upside down) and then rotated 180 degrees.
C) The airway is not introduced in a downward position.
D) The airway should be taped to prevent injury.
Page Ref: 497
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 11.5 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

17) The nurse is caring for a client with chronic obstructive pulmonary disease (COPD) who is experiencing increasing respiratory difficulty. The client has refused being placed on a mechanical ventilator and the nurse is aware that which would provide possible respiratory assistance to this client?
A) Place an endotracheal tube without the use of a mechanical ventilator.
B) Provide supplemental oxygen using a Venturi face mask.
C) Put a nonrebreather mask on the client to help him breathe.
D) Place the client on a bilevel positive airway pressure (BiPAP) machine.
Answer: D
Explanation: A) The client has refused intubation.
B) A Venturi face mask will not be sufficient for this client.
C) A nonrebreather mask will not be sufficient for this client.
D) The use of a CPAP or BiPAP machine may provide an appropriate alternative to intubation.
Page Ref: 498
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 11.5 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

18) The nurse is observing a new mother use a bulb syringe to suction her newborn's nose and mouth and should provide further instruction if the mother performs which action?
A) Begins the procedure by suctioning the infant's nose.
B) Deflates the bulb before placing the tip of the bulb syringe in the infant's nose.
C) Releases the bulb and removes the bulb syringe from the infant's nose.
D) Washes the bulb syringe with soap and water and then allows it to air dry.

Answer: A
Explanation: A) The mother should be taught to suction the infant's mouth before suctioning the infant's nose to prevent aspiration of secretions in the throat.
B) The bulb should be deflated before placing the syringe in the infant's nose.
C) The bulb should be released and then the syringe removed from the nose.
D) The syringe should be cleansed with soap and water and allowed to air dry.
Page Ref: 501
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Evaluation | Learning Outcome: 11.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

19) The nurse is preparing to do tracheostomy care for a client and should know that which must be present at the bedside before beginning this procedure?
A) One pair of sterile gloves
B) Obturator
C) Full-strength hydrogen peroxide
D) Sterile water
Answer: B
Explanation: A) Sterile gloves do not need to be kept at the bedside.
B) The nurse must have an obturator at the bedside in case the trach tube is inadvertently dislodged. The obturator will allow the tube to be reinserted immediately.
C) Hydrogen peroxide does not need to be kept at the bedside.
D) Sterile water does not need to be kept at the bedside.
Page Ref: 507
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Planning | Learning Outcome: 11.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

20) The nurse is caring for an older adult client who had a tracheostomy placed 3 days ago and should know that which issue will take priority when caring for this client?
A) Reducing the client's anxiety concerning self-care of the tracheostomy
B) Reassuring the client that the tracheostomy is a temporary measure
C) Ensuring that the skin around the client's tracheostomy stoma is assessed frequently
D) Referring the client to a support group for individuals with tracheostomies

Answer: C
Explanation: A) The client's anxiety can be addressed at another time.
B) There is no way of knowing if the tracheostomy is going to be temporary.
C) The nurse should place priority on caring for the skin around the client's stoma because older adults are more prone to skin breakdown.
D) The client is not ready to be referred to a support group.
Page Ref: 510
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 11.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

21) The nurse is preparing to provide tracheostomy care to a 6-month-old infant and should know that which takes priority when performing this procedure?
A) Teaching the parents how to perform the procedure
B) Ensuring that a second person is available to assist with the procedure
C) Completing the procedure while the infant is asleep to minimize traumatizing the infant
D) Use clean rather than sterile procedure because the infant will be going home with the tracheostomy
Answer: B
Explanation: A) Teaching the parents is not a priority when providing tracheostomy care.
B) An assistant should always be present while trach care is performed in an infant or child.
C) The infant does not need to be asleep when performing the procedure.
D) Tracheostomy care is a sterile procedure.
Page Ref: 510
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 11.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

22) The nurse is preparing to perform tracheostomy care on an alert, cooperative adult client and should request an assistant prior to which step?
A) An assistant is not required when performing tracheostomy care in a cooperative, alert adult client.

B) The assistant is required prior to pouring liquids into the sterile container.
C) The assistant is required prior to removing the inner cannula.
D) The assistant is required prior to removing and placing new tracheostomy ties.
Answer: D
Explanation: A) An assistant is required when the trach tapes are being changed.
B) An assistant is not needed when preparing the cleansing solution.
C) An assistant is not needed when removing the inner cannula.
D) The nurse requires assistance prior to changing the ties of the trach tube because it is at this time that the entire trach could be dislodged.
Page Ref: 510
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 11.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

23) The nurse is caring for a client who had a chest tube inserted 48 hours ago. During the first AM assessment, the nurse noted there was intermittent bubbling of the water in the water-seal chamber. When assessing the client 2 hours later, the nurse notes that the water is now continuously bubbling. Which is the nurse's priority action at this time?
A) Document the presence of the bubbling.
B) Immediately contact the healthcare provider.
C) Instruct the client to perform deep-breathing exercises.
D) Disconnect the chest tube from the drainage system and place the chest tube in a new chest tube drainage system.
Answer: B
Explanation: A) The nurse needs to do more than document the bubbling.
B) Because continuous bubbling in the water-seal chamber indicates a possible break in the system, the nurse should immediately notify the healthcare provider and follow any orders received.
C) Deep breathing is not going to change the amount of bubbling.
D) The chest tube system does not need to be changed.
Page Ref: 512
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 11.8 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

24) The nurse is caring for a client who has a chest tube. Upon assessment, the nurse notes that there is continuous bubbling of water in the suction container of the chest tube but very little if any bubbling in the water seal chamber. Which is the nurse's BEST action at this time?
A) Contact respiratory therapy for immediate assistance.
B) Reposition the client to the affected side.
C) Auscultate the client's lungs, paying close attention to the area near the chest tube.
D) Wait 15 minutes and reassess the client.
Answer: C
Explanation: A) The respiratory therapist does not need to be contacted.
B) The client does not need to be repositioned to the affected side.
C) Auscultation of the client's lungs should be the nurse's first action because the nurse needs to know if there continues to be lack of air movement (tube is blocked) or possible healing of air leak before contacting the healthcare provider.
D) The client should be assessed more frequently than 15 minutes.
Page Ref: 513
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 11.8 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

Clinical Nursing Skills: A Concept-Based Approach, 4e (Pearson)
Chapter 12 Perfusion

1) A nurse is providing care to a client on complete bed rest. Which is the BEST explanation by the nurse as to the function of sequential compression devices?
A) "Inflatable compartments compress legs in a graduated sequential fashion."
B) "An air compressor fills an inflatable sleeve, then allows the air to drain out of the sleeve."
C) "Proper measurement will provide adequate pressure on the legs to facilitate venous return."
D) "The function is to promote circulation in the upper legs."
Answer: A
Explanation: A) The compartment closest to the foot inflates first and the compartment closest to the thigh inflates last. The highest pressure is in the first compartment and the lowest in the last one. This creates a "milking" action to empty deeper veins of the lower leg to promote optimal blood flow.
B) The device does not use an air compressor to drain air out of the sleeve.
C) The device is not used to facilitate venous return.
D) The device is not used to promote circulation in the upper legs.
Page Ref: 540
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Planning | Learning Outcome: 12.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

2) The nurse is reading a 12-lead recording. Which lead will the nurse review as the BEST for monitoring atrial functioning?
A) Lead I
B) Lead II
C) Lead aVL
D) Lead aVF
Answer: B
Explanation: A) Lead I records activity between the two arms.
B) Lead II records activity between the arm and leg, and is best for monitoring atrial functioning.
C) Lead aVL records activity between the center of the heart and the left arm.
D) Lead aVF records activity between the center of the heart and the left leg or foot.
Page Ref: 544
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Evaluation | Learning Outcome: 12.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

3) The nurse is applying electrodes onto a client for an electrocardiogram. In which way will the nurse know that the electrodes have been placed properly?
A) Lights on the box come on when electrodes are placed properly.
B) Follow the picture on the box for proper placement of electrodes.
C) Call the base station to run an ECG strip to check the signal of transmission.
D) Electrodes are placed correctly unless notified by the monitoring station.
Answer: C
Explanation: A) The lights on the box are not used to ensure the electrodes have been correctly placed.
B) Following the picture on the box is not used to ensure the electrodes have been correctly placed.
C) The nurse needs to call and have the base station run an ECG strip to check the clarity of transmission when applying electrodes on a client being monitored by telemetry
D) Notification from the monitoring station is not how to ensure that the electrodes have been correctly placed.
Page Ref: 547
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Evaluating | Learning Outcome: 12.2 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

4) The nurse is placing electrodes on a client. Which is the correct placement of a 3-lead telemetry?
A) RA (white)-below right clavicle; LA (black)-below left clavicle; LL (red)-left lowest rib cage area
B) RA (white)-right wrist; LA (black)-left wrist; LL (red)-left leg
C) RA (green)-right lowest rib cage; LA (brown)-midaxillary line; LL (red) left lowest rib cage
D) RA (green)-below right clavicle; LA (black)-below left clavicle; LL (red)-left leg
Answer: A
Explanation: A) The correct placement for the 3-lead telemetry is RA (white)-below right clavicle; LA (black)-below left clavicle; LL (red)-left lowest rib cage area.
B) RA (white)-right wrist; LA (black)-left wrist; LL (red)-left leg is not correct.
C) RA (green)-right lowest rib cage; LA (brown)-midaxillary line; LL (red) left lowest rib cage is not correct.
D) RA (green)-below right clavicle; LA (black)-below left clavicle; LL (red)-left leg is not correct.
Page Ref: 547
Cognitive Level: Remembering
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Implementation | Learning Outcome: 12.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

5) In which way should the nurse calculate the heart rate from a rhythm strip?
A) Count the number of R waves in 30 large blocks and multiply by 10.
B) Count the number of small squares in a 3-second period and multiply by 0.20.
C) Count the number of large squares and multiply by 3.
D) Count the number of P waves in a 0.04 second and multiply by 5.
Answer: A
Explanation: A) Thirty large blocks equal a 6-second period, then multiply by 10 to obtain the heart rate. A normal rate is 60-100 beats/min.
B) The heart rate is not calculated by counting the number of small squares in a 3 second period.
C) The heart rate is not calculated by counting the numb of large squares and multiplying by 3.
D) The heart rate is not calculated by counting the number of P waves.
Page Ref: 548
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 12.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

6) A client with a history of heart disease has an irregular rhythm on the monitor. Which is the first action the nurse should implement?
A) Immediately initiate cardioversion.
B) Place oxygen on the client.
C) Administer calcium channel blockers.

D) Complete a cardiac assessment.
Answer: D
Explanation: A) More information is needed before initiating cardioversion.
B) There is no reason to apply oxygen to the client.
C) A calcium channel blocker would need to be prescribed by the healthcare provider.
D) The nurse needs to assess the client first to determine whether the abnormal rhythm is potentially life threatening or if there is something wrong with the telemetry monitor.
Page Ref: 546
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Assessment | Learning Outcome: 12.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

7) Which dysrhythmia should the nurse identify as life threatening?
A) P wave normal; atrial rate > 100; QRS complex width 0.06–0.08 second
B) P wave normal; atrial rate< 60; QRS complex width 0.08 second
C) P wave none identifiable; atrial rate disorganized activity greater 350 beats/min; QRS complex width irregular
D) P wave none; atrial rate cannot differentiate; ventricular rate 130–250 beats/min
Answer: D
Explanation: A) P wave normal; atrial rate > 100; QRS complex width 0.06–0.08 second is not life-threatening.
B) P wave normal; atrial rate < 60; QRS complex width 0.08 second is not life-threatening.
C) P wave none identifiable; atrial rate disorganized activity greater 350 beats/min; QRS complex width irregular is not life-threatening.
D) This is ventricular tachycardia.
Page Ref: 550
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 12.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

8) The nurse observes an irregular chaotic rhythm. Which arrhythmia should the nurse document?
A) Ventricular tachycardia
B) Ventricular fibrillation
C) Atrial flutter
D) Atrial fibrillation
Answer: B
Explanation: A) Ventricular tachycardia does not cause an irregular chaotic rhythm.
B) Ventricular fibrillation is an irregular, totally chaotic rhythm with fibrillating waves only.
C) Atrial flutter does not cause an irregular chaotic rhythm.
D) Atrial fibrillation does not cause an irregular, chaotic rhythm.
Page Ref: 551
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Assessment | Learning Outcome: 12.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

9) A client with a history of heart disease has a heart rate of 38 beats per minute. Which action should the nurse take after assessing the client?
A) Prepare the client for pacemaker insertion.
B) Start CPR at 100 chest compressions/minute.
C) Administer oxygen to maintain tissue perfusion.
D) Assign the UAP to monitor the client.
Answer: A
Explanation: A) The client is in third-degree heart block. Need to prepare client for a pacemaker insertion.
B) The client does not need CPR.
C) The client does not need oxygen.
D) The nurse should stay with the client.
Page Ref: 552
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Implementation | Learning Outcome: 12.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

10) The nurse is providing care to a client with an arrhythmia. For which arrhythmia will the nurse administer prescribed digoxin?
A) Atrial fibrillation
B) Atrial flutter
C) Premature ventricular contractions
D) Sinus bradycardia
Answer: A
Explanation: A) Digoxin is used to treat atrial fibrillation.
B) Digoxin is not the drug of choice to treat atrial flutter.
C) Digoxin is not the drug of choice to treat premature ventricular contractions.
D) Digoxin is not the drug of choice to treat sinus bradycardia.
Page Ref: 551
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Implementation | Learning Outcome: 12.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

11) A client asked the nurse "Why do I need to have this transcutaneous pacemaker?" Which is the most appropriate response by the nurse?
A) "It provides close monitoring by your healthcare provider."
B) "It delivers impulses and transmissions to the myocardium."
C) "It is for an emergency when you have an irregular rhythm."
D) "It is for symptomatic bradycardia that is unresponsive to atropine."
Answer: D
Explanation: A) Transcutaneous pacemakers are not used for monitoring.
B) Transcutaneous pacemakers are not used to deliver impulses to the heart.
C) Transcutaneous pacemakers are not used in an emergency for an irregular rhythm.
D) Transcutaneous pacemakers are used for symptomatic bradycardia unresponsive to atropine or high-degree atrioventricular block causing hemodynamic compromise.
Page Ref: 557
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Implementation | Learning Outcome: 12.5 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Knowledge and Science

12) A nurse is providing care to a client with a temporary pacemaker. The nurse observes a spike on the ECG. Which action should the nurse take first?
A) Notify the healthcare provider that the client is having an arrhythmia.
B) Document the client's rhythm, pacing spikes, and post strip in the client's chart.
C) Complete the pain assessment because this is an irregular finding and causes pain.
D) Delegate this client to the UAP until the temporary pacemaker is not needed.
Answer: B
Explanation: A) The spikes are not an arrhythmia.
B) This nurse needs to document the findings because this is a normal response to a client who has a temporary pacemaker.
C) The spikes do not cause pain.
D) The client's care should not be delegated to UAP.
Page Ref: 555
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Implementation | Learning Outcome: 12.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

13) The nurse is providing care to a client who has signs of pacemaker failure. Which will the nurse document for pacemaker failure? **Select all that apply.**
A) Bradycardia
B) Bradypnea
C) Decreased urine output
D) Increased blood pressure
E) Increase in temperature
Answer: A, C
Explanation: A) A decrease in cardiac output causes a decrease in urine output (CO = HR × SV).
B) Pacemaker failure causes shortness of breath.
C) The pacemaker functions to keep the heart rate above 60 beats/min. Bradycardia is less than 60 beats/min (CO = HR × SV).
D) Pacemaker failure causes a decrease in blood pressure.
E) Pacemaker failure does not affect body temperature.
Page Ref: 556
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Implementation | Learning Outcome: 12.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

14) The nurse is administering a blood transfusion to a client. Which action should the nurse implement first when a client is complaining of chills and back pain within the first 15 minutes of this transfusion?
A) Infuse normal saline.
B) Give the client a blanket.
C) Stop the infusion.
D) Notify the charge nurse.
Answer: C
Explanation: A) Normal saline is not infused first.
B) A blanket can be provided after the transfusion is stopped.
C) The nurse needs to stop the transfusion immediately at the first sign of an infusion reaction and reassess the client.
D) The charge nurse can be notified after the transfusion is stopped.
Page Ref: 534
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Implementation | Learning Outcome: 12.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

15) A client receiving a blood transfusion begins to have difficulty breathing and complains of itchiness. Which action should the nurse instruct a new graduate RN to take first?
A) Stop the infusion.
B) Call a code blue.
C) Reassess the client.
D) Administer albuterol.
Answer: A
Explanation: A) The nurse needs to stop the transfusion immediately at the first sign of an infusion reaction and reassess the client.
B) The client is not experiencing a cardiac arrest.
C) The client can be reassessed after the transfusion is stopped.
D) Albuterol is not used to treat a blood transfusion reaction.
Page Ref: 534
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Implementation | Learning Outcome: 12.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

16) The client diagnosed with anemia has the following laboratory values: hemoglobin 7.8 g/dL, platelets 150,000, white blood cells 4.7, and hematocrit 23.4%. Which laboratory result indicates the transfusion was effective after receiving 2 units of packed red blood cells?
A) Hemoglobin 11 g/dL

B) Platelets 130,000
C) White blood cells 5.3
D) Hematocrit 15%
Answer: A
Explanation: A) The hemoglobin increased, which indicates that the transfusion was effective.
B) Red blood cells will not affect the platelet level.
C) Red blood cells will not affect white blood cells.
D) The hematocrit is not used to evaluate the oxygen carrying capacity of the blood.
Page Ref: 530
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Implementation | Learning Outcome: 12.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.7 Evaluate outcomes of care.
NLN Competencies: Knowledge and Science

17) Before removing a unit of blood from the blood bank, which information should the nurse ask first?
A) Verify the client's name, date of birth, and blood type.
B) Review the signed consent form in the client's EMR.
C) Ask if any family members had a reaction to a blood transfusion.
D) Administer prescribed premedications before starting the blood transfusion.
Answer: B
Explanation: A) The client's name, date of birth, or blood type does not need to be reviewed first.
B) The nurse is aware that the blood is only good for 30 minutes at room temperature after leaving the blood blank, so the consent form needs to be signed before picking up the blood, in case the client refuses the transfusion.
C) A family history of blood transfusion reactions is not important information.
D) Premedication would be provided before the transfusion is started.
Page Ref: 530
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Implementation | Learning Outcome: 12.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

18) A new nurse asks the RN why blood needs to be hung within 30 minutes after leaving the blood bank. Which response should the nurse make?

A) "Coagulation occurs faster the warmer the blood gets."
B) "Rejection occurs when the blood is not administered cold."
C) "Risk for bacterial growth occurs as it gets warmer."
D) "An allergy will occur if administered when cold."
Answer: C
Explanation: A) The blood will not coagulate if left at room temperature.
B) Room temperature blood does not increase the risk of rejection.
C) As blood warms, the risk of bacterial growth increases. Make sure the unit of blood is left at room temperature for no more than 30 minutes before starting the transfusion.
D) Room temperature blood does not increase the risk of an allergic reaction.
Page Ref: 533
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Implementation | Learning Outcome: 12.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

19) The nurse receives a prescription to administer blood stat to a client receiving total parenteral nutrition (TPN). Which is the first action the nurse should implement?
A) Administer the blood.
B) Take vital signs.
C) Start a new IV line.
D) Premedicate the client.
Answer: C
Explanation: A) The blood should not be administered through the same route as the TPN.
B) Vital signs can be measured before giving the blood.
C) A new IV line with a #18 or #20 gauge is needed because TPN or any other solution is not compatible with blood unless it is normal saline. If unable to start an IV, will need to request another PICC line for the blood.
D) Premedication can be done before starting the transfusion.
Page Ref: 531
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Implementation | Learning Outcome: 12.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

20) The nurse is precepting a new graduate nurse who is preparing to transfuse blood. For which action by the new graduate nurse will the nurse intervene immediately?
A) Starts blood transfusion immediately upon return to unit
B) Primes infusion set with normal saline solution
C) Educates the client about possible side effects
D) Reviews client chart for history of allergies

Answer: A
Explanation: A) Blood must be verified by two RNs and not just by one RN before transfusion begins.
B) The infusion set should be primed with normal saline.
C) The client should be informed of potential adverse effects.
D) The client's medical record should be reviewed for a history of allergies.
Page Ref: 533
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Implementation | Learning Outcome: 12.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

21) The nurse is providing care to a client who has a sequential compression device (SCD) on both legs and is complaining of numbness and tingling in the left leg. Which is the first action the nurse should implement?
A) Assess capillary refill in the toes on the left foot.
B) Remove the SCD unit from left leg.
C) Notify the healthcare provider.
D) Administer pain medication.
Answer: B
Explanation: A) Capillary refill can be assessed after the SCD unit is removed.
B) The nurse needs to remove the SCD unit when the client is complaining of numbness and tingling to assess that leg.
C) The healthcare provider can be notified after the assessment is completed.
D) A pain assessment needs to be completed before providing pain medication.
Page Ref: 542
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Implementation | Learning Outcome: 12.8 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

Clinical Nursing Skills: A Concept-Based Approach, 4e **(Pearson)**

Chapter 13 Perioperative Care

1) The nurse has just completed teaching a client about postoperative leg exercises to prevent which postoperative complication?
A) Pneumonia
B) Pulmonary embolism
C) Atelectasis
D) Ileus
Answer: B
Explanation: A) Leg exercises are not used to prevent the development of pneumonia.
B) Leg exercises help to prevent the formation of blood clots that could become a pulmonary embolism.
C) Leg exercises are not used to prevent the development of atelectasis.
D) Leg exercises are not used to prevent the development of an ileus.
Page Ref: 572
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 13.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

2) The nurse is preparing four older adult patients for surgery and knows that which client is at highest risk for postoperative pressure injury development?
A) The client who regularly attends the local senior center for socialization and meals and takes diphenhydramine (Benadryl) at night for sleep
B) The client who walks one mile every other day and takes ibuprofen twice a day for arthritis in his knees
C) The client who babysits every day and takes prednisone daily for allergies
D) The client who drives a bus every week and takes fluoxetine (Prozac) for anxiety
Answer: C
Explanation: A) Diphenhydramine does not increase the risk for pressure injury development.
B) Ibuprofen does not increase the risk for pressure injury development.
C) Prednisone can cause increased bruising and skin breakdown and will increase the client's risk for pressure wound development.
D) Fluoxetine does not increase the risk for pressure injury development.
Page Ref: 573
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 13.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

3) The circulating nurse calls for a "time out" prior to the onset of a surgical procedure and knows that which client will not have a visible mark at the site of surgery?
A) The client who is having a right bunionectomy
B) The client who is having a left knee replacement
C) The client who is having removal of a melanoma on the right arm
D) The client who is having a splenectomy
Answer: D
Explanation: A) A visible mark is needed for a bunionectomy.
B) A visible mark is needed for a knee replacement.
C) A visible mark is needed to remove a melanoma.
D) Single-organ surgeries such as a splenectomy do not need to be marked.
Page Ref: 585
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 13.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

4) The nurse is conducting preoperative teaching for an older adult client who will be having outpatient cataract surgery. Which statement by the nurse indicates the BEST approach to safely teaching this client?
A) "Be at the eye surgery center at 6 AM, wear loose-fitting clothes, and make sure that you bring someone with you who can take you home."

B) "Please do not eat or drink anything after 10 PM the night before surgery."
C) "Please read this information about cataract surgery and I'll be back in a few minutes to answer any questions you may have."
D) "I see that your spouse had a cataract removed with us last year. Everything will be about the same for your surgery."
Answer: B
Explanation: A) Multiple instructions should not be given.
B) The nurse is giving the client one instruction at a time to allow time for the information to be processed or repeated.
C) The client is having cataract surgery and might not be able to read instructions.
D) It is inappropriate to assume the client's surgery will be the same as the spouse's surgery.
Page Ref: 573
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 13.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

5) The nurse is performing a surgical hand scrub prior to entering the operating room. The circulating nurse will stop the nurse and reinstruct on proper hand scrubbing if the nurse does which action?
A) After wetting the hands and forearms, the nurse holds the hands above the level of the elbows.
B) The nurse spends 25 to 30 seconds rubbing soap on the tops and palms of hands using an up-and-down motion.
C) The nurse keeps the arms elevated and backs into the operating room.
D) The nurse uses a sterile towel to dry one hand from fingers to the elbow and then picks up a second sterile towel for the other hand.
Answer: B
Explanation: A) The hands should be held above the level of the elbows.
B) Circular strokes clean more effectively. Rubbing is necessary but an up-and-down motion will not provide effective cleaning.
C) The arms should be elevated while backing into the operating room.
D) The hands should be dried with a sterile towel.
Page Ref: 574
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 13.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

6) The nurse is preparing to complete hand hygiene using an alcohol-based rub and knows that how much hand rub product will be required for adequate hand cleansing?
A) 0.5-1.5 mL
B) 2-4 mL
C) 5-6 mL
D) 8-10 mL
Answer: C
Explanation: A) Less than 6 mL of hand rub is not sufficient.
B) Less than 6 mL of hand rub is not sufficient.
C) It takes approximately 6 mL for adequate hand cleansing.
D) More than 6 mL is not necessary.
Page Ref: 575-576
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 13.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

7) The nurse is caring for a client who had abdominal surgery three days ago. The client is able to drink fluids but is reluctant to eat anything for fear of nausea and vomiting. The nurse encourages the client to try and eat to prevent which postoperative complication?
A) Dehydration
B) Pneumonia
C) Urinary retention
D) Delayed wound healing
Answer: D
Explanation: A) Adequate nutrition does not prevent dehydration.
B) Adequate nutrition does not prevent pneumonia.
C) Adequate nutrition does not prevent urinary retention.
D) Adequate nutrition is needed to support wound healing and muscle strength.
Page Ref: 573
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 13.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

8) The nurse is preparing a sterile field prior to a wet to dry dressing change and notices that the corner of the sterile drape is damp. Which action should the nurse take?
A) Continue with the procedure because the dampness is in the area already considered to be contaminated.

B) Put down a fresh drape but use the liquids that have already been poured.
C) Begin the procedure from the beginning, including pouring fresh liquids.
D) Wait 5 minutes to see if the damp area will move into the area considered sterile. If the sterile area becomes damp, begin again with fresh supplies.
Answer: C
Explanation: A) The sterile field is contaminated and should not be continued.
B) A fresh drape will not be sufficient.
C) Once there is the possibility of contamination, fresh supplies must be used.
D) Waiting 5 minutes is not sufficient.
Page Ref: 579
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 13.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

9) The nurse has been asked to assist a healthcare provider with a sterile procedure at the client's bedside. The nurse enters the client's room to find a non-covered sterile field set out on the client's bedside table but the healthcare provider has left the room. Which action should the nurse take at this time?
A) Nothing; it is not the nurse's responsibility.
B) Leave the room and wait until the healthcare provider enters the room again before reentering.
C) Ask the client how long the healthcare provider has been out of the room.
D) Request that the healthcare provider set up a new sterile field.
Answer: D
Explanation: A) The nurse is responsible for the client's care.
B) The sterile field should not be left unattended.
C) It is not the client's responsibility to watch the sterile field.
D) An unobserved sterile field is now considered contaminated and should be discarded and a fresh one laid out.
Page Ref: 579
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 13.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

10) The nurse enters a room in preparation for a sterile dressing change. Which must the nurse do before preparing the sterile field?
A) Turn the room fan off.
B) Open the blinds in the room.
C) Request the client perform hand hygiene.
D) Increase the temperature in the room 10 degrees to prevent chilling the client.
Answer: A
Explanation: A) The room fan should be turned off because air movement should be minimized to prevent airborne contamination.
B) The window blinds can remain open.
C) The client does not need to perform hand hygiene.
D) The temperature in the room does not need to be increased.
Page Ref: 579
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 13.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

11) The nurse is preparing a client for surgery and asks the client to remove his dentures and place them in the specified cup at the bedside. The client states, "Why are you asking me to do this? The last time I had surgery I got to keep my dentures in my mouth." Which is the nurse's BEST response to this client statement?
A) "You may have thought you kept them in. I'm guessing your dentures were removed after you went to sleep and were returned to your mouth before you were completely awake."
B) "Some anesthesiologists allow a client to keep a full set of dentures in the mouth if a specific type of anesthesia is given."
C) "I've never heard of anyone keeping their dentures in for surgery. You must remove them."
D) "I'm sorry that you don't want to do this. You must take them out or your surgery will be canceled."
Answer: B
Explanation: A) It is unlikely that the dentures were removed in the operating suite.
B) Some anesthesiologists allow clients to wear a full set of dentures if anesthesia is administered by mask.
C) There are some situations in which dentures can remain in the mouth during surgery.
D) The client should not be threatened about the dentures.
Page Ref: 584
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 13.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Knowledge and Science

12) The nurse is caring for a client who is being prepared for surgery. Due to a motorcycle crash 10 years ago, the client has a prosthetic right arm, prosthetic left leg, prosthetic left eye, and wears hearing aids. The client also wears a wedding ring that cannot easily be removed from the client's finger. Which statement by the nurse indicates the proper way of preparing the client for surgery?
A) "Please remove your hearing aids and your prosthetic leg, arm, and eye. I am going to securely tape your ring in place. "
B) "Please remove your hearing aids and prosthetic leg and arm. I will place tape over your left eye and tape on your ring to hold them both in place during the surgery."
C) "I need for you to remove your hearing aids, and all of your prosthetics. I am going to get some oil to put on your finger because your ring must be removed prior to surgery."
D) "I'm sure you know the drill because you have had many surgeries before. Please remove anything that is not your original equipment."
Answer: A
Explanation: A) The hearing aids and prosthetics must be removed but the ring may be securely taped in place.
B) All artificial devices and prostheses need to be removed before the surgery.
C) All artificial devices and prostheses need to be removed before the surgery.
D) All artificial devices and prostheses need to be removed before the surgery.
Page Ref: 58583-584
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 13.5 | QSEN Competencies: Safety

AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

13) The nurse is caring for a client who had a knee replacement completed 2 days ago. When changing the knee dressing, the nurse notes that the incision appears red and feels warm to the touch. The client's temperature is now 100.6 degrees F and the client states that the knee hurts worse now than it did the day after surgery. After calling the surgeon, the nurse anticipates which to be ordered for this client?
A) Keep the client NPO and prepare for the client to be returned to surgery.
B) Restart the client's IV and give fluids and pain medication.
C) Culture any drainage that is present and administer fluids and antibiotics.
D) Provide anticoagulant therapy and place the client on oxygen.
Answer: C
Explanation: A) There is no reason to prepare the client for surgery.
B) The client may not need intravenous fluids and pain medication.
C) Any drainage should be cultured and antibiotics and possibly fluids will be started.
D) There is no reason for the client to receive anticoagulants and oxygen.
Page Ref: 571
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 13.6 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

14) The nurse is preparing to change the dressing of a surgical client and will be alert for which signs or symptoms of a wound infection? **Select all that apply.**

A) Cool to the touch
B) Redness
C) Serosanguinous drainage
D) Client temperature of 101 degrees F
E) Pain rating of 2 out of 10
Answer: B, D
Explanation: A) Coolness indicates a reduction in blood flow.
B) Redness at the incision site is an indication of a wound infection.
C) Serosanguineous drainage would occur after surgery.
D) Fever or elevated client temperature is an indication of a wound infection.
E) A pain rating of 2 would be expected after surgery.
Page Ref: 571
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 13.6 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

15) Immediately prior to placing the client on a gurney for surgery, the nurse asks the client to remove the partial plate dentures. The client becomes upset and states, "No one can see me without my teeth. I am so embarrassed by the way I look without them." Which response will the nurse make?
A) "I realize this is hard for you to do. I will ask the nurse in surgery to remove them for you after you go to sleep."
B) "Why don't you take them out and drape this washcloth over your face so no one can see you without your teeth?"
C) "Leaving your teeth in during surgery may cause injury to you or your teeth. Here is the cup for your dentures. Take them out right before surgery and then you can place them back in your mouth as soon as you wake up."
D) "This is just something you have to put up with when you have surgery. No one knows you here so it won't be that embarrassing."
Answer: C
Explanation: A) The dentures should be removed before going into the surgical suite.
B) There is no reason for the client to drape a washcloth over the face.
C) Explaining the reason for removing the dentures is important. Then, giving a safe option of the client is important also.
D) The nurse should be sensitive to the client's self-image.
Page Ref: 585
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 13.8 | QSEN Competencies: Safety

AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

16) The nurse is caring for an older adult client who is being prepared for abdominal surgery. During the preoperative assessment, the nurse notes that the client has a nonproductive cough but all lung sounds appear normal. With regard to this finding, which preoperative teaching will take priority with this client?

A) Postoperative nutrition

B) Pursed-lip breathing

C) Use of incentive spirometer

D) Bed leg exercises

Answer: C

Explanation: A) Nutrition will not help prevent a postoperative respiratory infection.

B) Pursed-lip breathing will not be sufficient to prevent a postoperative respiratory infection.

C) Use of the incentive spirometer would take priority because it causes the client to take deep breaths and would help prevent the development of pneumonia in the older adult client.

D) Leg exercises will not prevent a postoperative respiratory infection.

Page Ref: 572

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: Nursing Process: Implementation | Learning Outcome: 13.2 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.

NLN Competencies: Quality & Safety

17) The nurse is researching the literature to determine the best method to perform hand hygiene to prevent a postsurgical wound infection and has determined that which method has been determined to be the BEST?

A) Hand hygiene using a surgical scrub brush and very hot water works best to prevent infection.

B) Performing hand hygiene using an alcohol-based rub has been shown as the best method to prevent postoperative infection.

C) Prior to surgery, washing the hands with soap and water and finishing with an alcohol-based hand wash is the best method to prevent infection.

D) Research has not determined whether hand washing with soap or the use of alcohol-based hand hygiene is better at preventing infection.

Answer: D

Explanation: A) There is no evidence that a surgical scrub with hot water is better to prevent an infection.

B) Alcohol-based rubs have not been proved to be better than soap and water.

C) There is no need to use both soap and water and an alcohol-based rub.

D) Research has shown that surgical hand antisepsis is necessary but it does not state which method has an advantage over the other.

Page Ref: 576

Cognitive Level: Applying

Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control

Standards: Nursing Process: Implementation | Learning Outcome: 13.3 | QSEN Competencies: Evidence-Based Practice

AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.

NLN Competencies: Quality & Safety

18) The nurse is preparing a client for inguinal hernia surgery, which will require hair to be removed from the inguinal region. The nurse informs the client that this hair removal is completed at which time in relation to the surgery?
A) The nurse will instruct the client on completing a preoperative shave with a safety razor on the night prior to the surgery.
B) The nurse will instruct the client to complete the preoperative shave with a safety razor on the morning of the surgery prior to coming to the hospital.
C) The nurse will explain that the preoperative shave will be completed using an electric clipper after the client arrives at the hospital the morning of surgery.
D) The nurse will tell the client that the preoperative shave will be completed by the surgeon in the operating room immediately prior to the beginning of the surgery.
Answer: C
Explanation: A) The client is not to shave themselves.
B) The client is not to shave themselves.
C) The hair is removed as close to the surgery as possible, using a clipper or scissors or depilatory cream.
D) The surgeon does not remove the hair.
Page Ref: 576-577
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 13.6 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

19) The nurse is preparing to do preoperative teaching for a client who will have abdominal surgery. Which preoperative teaching will the nurse emphasize for this client to assist the client with early ambulation? **Select all that apply.**
A) How to get out of bed after surgery
B) Requesting pain medication before the pain is severe
C) Using an incentive spirometer
D) How to turn in bed to prevent skin breakdown
E) Splinting the incision before coughing
Answer: A, B
Explanation: A) In an effort to promote early ambulation, it is important for the nurse to teach the client how to get out of bed.
B) The client needs to understand that pain control is necessary so that the client will be able to ambulate after surgery.
C) An incentive spirometer will not help with ambulation.
D) Turning in bed helps prevent skin breakdown.
E) Splinting the incision helps prevent wound dehiscence.
Page Ref: 572
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 13.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

20) The nurse is preparing the room for a client who is having surgery to repair a tibial fracture. In an effort to promote early ambulation, the nurse will have which safest assistive device available for the client?
A) Cane
B) Walker
C) Crutches
D) Wheelchair
Answer: B
Explanation: A) A cane would not be used to safely ambulate after repair of a tibial fracture.
B) A walker would be the safest device for the client to have that would support early ambulation.
C) Crutches would not be used to safely ambulate after repair of a tibial fracture.
D) A wheelchair would not be used to safely ambulate after repair of a tibial fracture.
Page Ref: 572
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 13.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

Clinical Nursing Skills: A Concept-Based Approach, 4e (Pearson)
Chapter 14 Reproduction

1) The certified nurse-midwife (CNM) is doing the first prenatal assessment on a client who states she believes she is 6 weeks pregnant. Which assessment finding by the CNM would indicate that this is the correct gestational age?
A) The fundus is palpable just above the symphysis.
B) Chadwick's sign is noted.
C) The fetal heart rate is obtained with a fetoscope.
D) Colostrum is able to be expressed from the nipple.
Answer: B
Explanation: A) The fundus is palpable just above symphysis at 10–12 weeks.
B) Chadwick's sign (bluish color of the cervix) may be seen at 4 to 8 weeks.
C) The fetal heart rate may be heard with a Doppler at 6–8 weeks' gestation; with fetoscope at 7–8 weeks.
D) Colostrum appears in late first trimester or early second trimester.
Page Ref: 592
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 14.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

2) The nurse is discussing anticipated weight gain with a client who has a BMI of 32. Which statement by the client indicates understanding of the topic?
A) "I know that because I am overweight my baby already has access to sufficient nutrients and I should attempt to keep my weight stable through the pregnancy."
B) "No matter what I weigh when I am pregnant, you should attempt to gain 25 to 30 lb. so that my baby will be born healthy."
C) "I will need to watch what I eat and make sure that I am eating a nutritious diet and I will try and limit my weight gain to less than 20 lb."
D) "I will limit what I eat while I am pregnant so I can begin to lose weight and to ensure that my baby is not born fat."
Answer: C
Explanation: A) The client will need to gain some weight during the pregnancy.
B) The client should not gain 25 to 30 lbs.
C) An obese woman should watch her diet to ensure that the calories she consumes are the most nutritious and attempt to limit weight gain to 15 to 20 lb.
D) The client should not diet to lose weight while pregnancy.
Page Ref: 591
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Evaluation | Learning Outcome: 14.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.7 Evaluate outcomes of care.
NLN Competencies: Knowledge and Science

3) A 16-year-old client comes to the prenatal clinic and is very concerned about a black line that has appeared on her abdomen. Which statement by the nurse will be most helpful to this client concerning this issue?
A) "This line occurs depending upon the sex of your baby. I don't want to tell you which one in case you don't know the gender of your baby yet."
B) "This line indicates that you are getting too much iron in your diet. You need to reduce the amount of red meat you are eating."
C) "This line is called the *linea nigra* and is related to the increase in your hormones during pregnancy."
D) "Please don't be worried about this. It is normal and it will go away after you have your baby."
Answer: C
Explanation: A) The linea nigra does not occur based upon the sex of the baby.
B) It does not mean that the client is getting too much iron.
C) The *linea nigra* is related to increased hormone levels and should fade considerably after the birth of the baby.
D) The nurse should explain what the line means.
Page Ref: 591
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Implementation | Learning Outcome: 14.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Knowledge and Science

4) The nurse is assessing a client who is 36 weeks pregnant. Her current pulse is 101 bpm, which represents an increase of 10 bpm since her first assessment at 9 weeks of gestation. Which is the nurse's BEST action related to this assessment finding?
A) Document the finding because it is considered within normal limits.
B) Retake the pulse in 15 minutes and ask the client to lie quietly during this time.
C) Teach the client to take her pulse and to record it twice a day.
D) Report the assessment finding to the healthcare provider (HCP) immediately.
Answer: A
Explanation: A) An increase in the pulse rate of approximately 10 bpm during pregnancy is considered normal and should be documented.
B) The pulse does not need to be rechecked.
C) The client does not need to check the pulse twice a day.
D) The healthcare provider does not need to be notified.
Page Ref: 591
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 14.1 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Knowledge and Science

5) The nurse is caring for a woman who has been diagnosed with preeclampsia and has been placed on intravenous magnesium sulfate to prevent seizures. After checking the patellar deep tendon reflex, the nurse documents the response as 2+. Which is the nurse's next action after this assessment?
A) Immediately discontinue the magnesium sulfate because the patellar response indicates hyporeflexia.
B) Check the deep tendon reflex in the biceps to see if it agrees with the patella.
C) Turn the client on the side to prevent aspiration during the anticipated seizure.
D) Ensure that the IV site is patent and that the magnesium sulfate is infusing adequately.
Answer: B
Explanation: A) The magnesium sulfate does not need to be discontinued.
B) It is common for the nurse to check two different reflexes, so the nurse would assess another reflex after assessing the patella.
C) The client does not need to be turned onto the side.
D) There is no reason to assess the intravenous site for patency.
Page Ref: 595
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Assessment | Learning Outcome: 14.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

6) The nurse is assessing a pregnant client who is at 29 weeks gestation. The nurse notes that the client's blood pressure is 160/90 and documents that the clonus was noted after assessing the patellar reflex. Which assessment findings led the nurse to document this finding?
A) There was no response when the area directly above the knee was struck with the percussion hammer.
B) The nurse noted an extension of the leg when the percussion hammer touched the area above the knee.
C) The client complained of pain when the foot was dorsiflexed.
D) The client's foot tapped against the nurse's hand when it was dorsiflexed.
Answer: D
Explanation: A) A lack of response is not identified as clonus.
B) The knee-jerk response is expected when eliciting the patellar reflex.
C) Pain is not documented as clonus.
D) When the foot taps or jerks against the hand of the nurse who dorsiflexes the client's foot, it indicates clonus and may indicate severe hyperreflexia.
Page Ref: 595
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 14.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

7) The nurse is performing the first Leopold maneuver on a client of 34 weeks gestation and notes the presence of fetal bottom and legs. The nurse knows that this maneuver would indicate which for this client?
A) The fetus' head is in the pelvis but positioned in a posterior fashion.
B) The fetus is in a breech position and a caesarean section may be required at birth.
C) The fetus' size does not match its gestational age.
D) The fetus is in position for immediate delivery and the healthcare provider should be notified immediately.
Answer: B
Explanation: A) The fetal head in the pelvis but positioned posteriority does not describe the finding when conducting the Leopold maneuver.
B) The presence of bottom and feet indicates that the fetus is in a breech position and a caesarean section may be necessary at birth.
C) This finding does not indicate that the fetal size does not match gestational age.
D) This finding does not indicate that the fetus is in position for immediate delivery.
Page Ref: 592
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 14.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

8) The nurse is admitting a client to the labor and delivery unit who states she is at 39 weeks and began having steady contractions approximately 6 hours ago. Which assessment findings discovered during the nurse's vaginal examination would indicate that this client will deliver within the next few hours? **Select all that apply.**
A) The client's cervix is dilated 7 centimeters.
B) The client's cervix is effaced 20%.
C) The presenting part of the fetus is at -4 station.
D) The client's membranes appear to have ruptured.
E) There is the presence of a bloody show on the nurse's gloved hand.
Answer: A, D, E
Explanation: A) Cervical dilation of 7 cm indicates that labor is progressing and birth can be expected within the next few hours.
B) Cervical effacement of 20% does not indicate pending delivery.
C) The fetal position at -4 does not indicate pending delivery
D) Ruptured membranes indicate that birth will occur soon.
E) Bloody show on the nurse's glove indicates that the client's mucous plug has been lost and is indicative that the client is in the active stage of labor.
Page Ref: 609
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 14.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

9) The nurse assesses the fundus of a client who delivered 6 hours ago and notes that it is 2 centimeters above the umbilicus and is displaced to the right. Which is the nurse's BEST action at this time?
A) Begin to massage the fundus.
B) Attempt to move the fundus back to midline.
C) Request the client go to the bathroom and void.
D) Determine if this client has had more than one child in the last 3 years.
Answer: C
Explanation: A) The fundus should not be massaged.
B) The nurse should not attempt to move the fundus back to midline.
C) A fundus that is elevated and displaced to the right indicates that the client's bladder may be full. The nurse should ask the client to void and then check again.
D) The number of children the client has had has nothing to do with the location of the fundus.
Page Ref: 610
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Implementation | Learning Outcome: 14.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

10) The nurse receives a call from a primapara who is at 37 weeks gestation. The client states, "I just wanted to let you know that we are on our way to the hospital. All of a sudden, my belly dropped so I know that I will be delivering the baby very soon." Which is the nurse's BEST response to this client?
A) "Just stay home because there is no way to tell when your labor will start."
B) "If you would like to come in and be checked that will be fine, but this drop only indicates your baby is getting ready for labor, not that it will start soon."
C) "I think you need to come in because once the head drops, labor can begin at any minute."
D) "I can't stop you from coming in, but I don't recommend it. You are just going to have a long wait for nothing."
Answer: B
Explanation: A) Lightening and dropping occurs 2 weeks before active labor.
B) This response gives the control to the client and explains what has just occurred.
C) Labor is not going to start at any time.
D) The client should be given the option to be examined.
Page Ref: 593
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Implementation| Learning Outcome: 14.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.2 Communicate effectively with individuals.
NLN Competencies: Knowledge and Science

11) The nurse is caring for a client who is in active labor and has just had an amniotomy. The nurse notes that the fetal heart rate has decreased from 140 bpm immediately prior to the amniotomy to 95 bpm. Upon vaginal examination, the nurse feels a portion of the umbilical cord in the vagina. Which is the nurse's next action in caring for this client?
A) Carefully push the umbilical cord back into the vagina with a sterile gauze.
B) Immediately place the client in reverse Trendelenburg and prepare to move the client to the operating room for a caesarean section.
C) Assist the client to the knee-chest position and notify the healthcare provider.
D) Place oxygen on the client at 2 L/min per nasal cannula and turn the client to the left side.
Answer: C
Explanation: A) The umbilical cord should not be pushed back into the vagina.
B) The Trendelenburg position should not be used.
C) If the umbilical cord is palpated in the vagina, the nurse should assist the client to the knee-chest position as quickly as possible and hold pressure on the presenting part to keep it off the cord and notify the healthcare provider.
D) Oxygen does not need to be applied nor does the client need to be placed on the left side.
Page Ref: 613
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 14.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

12) The nurse is using a Doppler for obtaining the fetal heart tone of a client who is at 28 weeks gestation and obtains a rate of 98 bpm. Which is the nurse's next action for this client?
A) Take the client's pulse while monitoring the fetal heart rate.
B) Massage the client's abdomen and retake the fetal heart tone.
C) Distract the client and retake the fetal heart tone.
D) Request that the healthcare provider (HCP) assess the client for possible fetal compromise.
Answer: A
Explanation: A) When obtaining the fetal heart rate, the nurse should be prepared to compare the client's heart rate with the fetal heart rate obtained. If they are the same, the Doppler is actually hearing the client's heart rate.
B) The abdomen does not need to be massaged.
C) The client does not need to be distracted.
D) The healthcare provider does not need to be contacted.
Page Ref: 603
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 14.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

13) The nurse is caring for a client who is 6 cm dilated with a fetus who has been diagnosed with a serious congenital heart defect. The client has rejected the use of continuous fetal monitoring so the nurse will use the Doppler and monitor the fetal heart rate (FHR) at what frequency?
A) Every 45 minutes
B) Every 30 minutes
C) Every 15 minutes
D) Every 5 minutes
Answer: C
Explanation: A) The high-risk client in the first stage of labor should have the FHR monitored more often than every 45 minutes.
B) The high-risk client in the first stage of labor should have the FHR monitored more often than every 30 minutes.
C) The high-risk client in the first stage of labor should have the FHR monitored every 15 minutes.
D) The high-risk client in the first stage of labor does not need to have the FHR monitored every 5 minutes.
Page Ref: 604
Cognitive Level: Understanding
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 14.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

14) The nurse is caring for a client at 33 weeks gestation who is being monitored for possible preeclampsia. The nurse prepares to check the client's patellar deep tendon reflex and places the client in which position?
A) Ask the client to lay on her left side with the right leg slightly bent and the nurse supporting the client's knee.
B) Request the client lie on her back with the knees bent while the nurse supports the legs.
C) Sit the client up in bed with the knees bent and the feet resting on the bed.
D) Assist the client to a chair next to the bed and ask the client to cross her legs.
Answer: B
Explanation: A) The client does not need to be turned onto the left side.
B) To elicit a patellar deep tendon reflex on an inpatient, the client is asked to lie supine with the knees flexed with the nurse supporting the client's leg.
C) The client should not sit up in bed for this assessment.
D) The client does not need to sit in a chair for this assessment.
Page Ref: 595
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 14.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

15) The nurse is assisting the health care provider with the first prenatal exam of a client. Prior to the vaginal speculum examination, which information should the nurse give the client to improve the client's comfort during the examination?
A) "Right when the speculum is being inserted in your vagina, you should hold your breath."
B) "As the speculum is being inserted, clench your fists as tightly as possible."
C) "It will help if you begin to do isometric exercises with your hands so you won't think about the speculum being inserted in your vagina."
D) "You need to bear down as the speculum is being inserted because it will help you relax."
Answer: D
Explanation: A) The client should not hold their breath before the speculum is inserted.
B) The fists should not be clenched when the speculum is being inserted.
C) Isometric exercises will not help relax when the speculum is being inserted.
D) Asking the client to bear down at the time of speculum insertion helps to open the vaginal orifice and relaxes the perineal muscle.
Page Ref: 595
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Implementation | Learning Outcome: 14.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

16) The nurse is admitting a client at full term to the labor and delivery unit. Using Leopold's maneuvers, the nurse determines that the fetus is in the left sacroanterior (LSA) position and will obtain the fetal heart rate (FHR) at which site on the client's abdomen?

A) Midline, directly above the symphysis pubis
B) To the right of the client's umbilicus
C) To the left of the client's umbilicus
D) To the left, below the umbilicus
Answer: B
Explanation: A) The fetal heart rate will not be obtained at the midline when the fetus is in the LSA position.
B) The fetus is in the LSA, which means it is in the breech position and the back of the fetus is to the right so the FHR will best be heard on the client's right side around the level of the umbilicus.
C) The fetal heart rate will not be to the left of the umbilicus when the fetus is in the LSA position.
D) The fetal heart rate will not be to the left below the umbilicus when the fetus is in the LSA.
Page Ref: 602
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 14.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

17) The nurse is admitting a client to the labor and delivery unit and is preparing to apply the tocodynamometer (toco). Which must the nurse do first to properly apply this equipment?
A) Apply ultrasound gel to the client's abdomen before applying the toco.
B) Determine the fetal position.
C) Locate the uterine fundus.
D) Ensure that the client's membranes have ruptured.
Answer: C
Explanation: A) Gel is not used with a tocodynamometer.
B) The fetal position does not need to be determined prior to using the tocodynamometer.
C) The toco should be placed over the uterine fundus because this area is the firmest during a contraction.
D) The client's membranes do not need to be ruptured to use the tocodynamometer.
Page Ref: 602
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Planning | Learning Outcome: 14.5 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

18) The nurse has completed applying the ultrasound transducer to the client's abdomen and has confirmed that the rate is not the same as the client's. Which other assessment will assist the nurse in confirming that the sound that is heard is the true fetal heart rate (FHR)?
A) The rate is slightly different at each assessment time.

B) The sound of the FHR is louder than the sound of the contraction.
C) The FHR will be approximately twice the rate of the client's.
D) The FHR will have a whip-like sound.
Answer: D
Explanation: A) A different rate does not confirm a true FHR.
B) The volume of the sound does not confirm a true FHR.
C) The rate being twice the rate of the client's does not confirm a true FHR.
D) The FHR will have a whip-like sound, which will help confirm that the sound heard is the fetal heart rate.
Page Ref: 602
Cognitive Level: Analyzing
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 14.5 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

19) The nurse is caring for a client who is prescribed to have labor induced with oxytocin. Which assessments must be completed by the nurse before initiating the oxytocin infusion? **Select all that apply.**
A) Record the fetal heart rate for 15 minutes.
B) Obtain the client's pain level.
C) Explain to the client that she should expect to be nauseated.
D) Determine the client's hydration status.
E) Apply the tocodynamometer and observe for any contractions.
Answer: A, D, E
Explanation: A) Prior to beginning the infusion, a baseline of fetal activity should be established.
B) The client's pain level does not need to be assessed prior to beginning the oxytocin infusion.
C) Oxytocin does not cause nausea.
D) It is important to establish the client's hydration status so that uterine hyperstimulation can be avoided.
E) A baseline of uterine activity should be established before medicating the client.
Page Ref: 607
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Assessment | Learning Outcome: 14.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

20) The nurse is caring for a client receiving oxytocin for induction of labor and notes that the client's contraction pattern shows a duration of 100 seconds and a frequency of 90 seconds. Which is the nurse's next action at this time?
A) Document the contraction pattern.
B) Inform the healthcare provider that a birth is imminent.
C) Stop the oxytocin.
D) Increase the oxytocin because the contractions are not adequate.
Answer: C
Explanation: A) The nurse needs to do more than documenting the contraction pattern.
B) Birth is not necessarily imminent.
C) The oxytocin must be stopped immediately because the uterus is hyperstimulated, which is preventing adequate oxygen from getting to the fetus.
D) Oxytocin does not need to be increased.
Page Ref: 607
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies
Standards: Nursing Process: Intervention | Learning Outcome: 14.6 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

21) The nurse is precepting a graduate nurse who is caring for a client who received an insertion of misoprostol at 8 AM. The client has not had any contractions since this was inserted. At 10 AM, the graduate nurse prepares to hang the oxytocin. Which should the precepting nurse do at this time?

A) Remind the graduate nurse that a contraction pattern must be established before the oxytocin may be started.

B) Inform the graduate nurse that there must be a 4-hour window between the insertion of misoprostol and the initiation of oxytocin.

C) Assist the graduate nurse in preparing the infusion.

D) Request the graduate nurse be removed from the labor and delivery unit for incompetence.

Answer: B

Explanation: A) A contraction pattern does need to be established before the oxytocin is started however it is not time to start the infusion.

B) The new nurse should not start the oxytocin until at least 12 PM because there must be a 4-hour window between the insertion of the misoprostol and the beginning of the oxytocin.

C) It is too early to start the infusion.

D) The graduate nurse is not incompetent.

Page Ref: 607

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Pharmacological and Parenteral Therapies

Standards: Nursing Process: Intervention | Learning Outcome: 14.6 | QSEN Competencies: Safety

AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.

NLN Competencies: Quality & Safety

22) The nurse is caring for a client who delivered twins 2 days ago. During the morning assessment, the nurse notes that the fundus is firm and located midline and at the level of the umbilicus. Which should the nurse do in light of this information?

A) Contact the healthcare provider and request a medication to return the uterus to a normal position.

B) Ask the client to void and recheck the level of the fundus.

C) Check the previous assessments to confirm that the fundus is decreasing daily.

D) Massage the fundus until there is evidence that it has reduced in size.

Answer: C

Explanation: A) Medication is not used to help the uterus return to position.

B) The fundus is midline.

C) The nurse should check the prior assessment to determine where the fundus started immediately after birth and that it has been progressively getting smaller.

D) The fundus does not need to be massaged.

Page Ref: 621

Cognitive Level: Applying

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: Nursing Process: Intervention | Learning Outcome: 14.7 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.

NLN Competencies: Knowledge and Science

23) The nurse is caring for a client who had a cesarean section 4 hours ago. The client refuses to let the nurse complete the fundal assessment. Which statement is the BEST response to this problem?
A) "I will just gently lay my hand on your abdomen. I won't go near your incision."
B) "I will give you your pain medicine and then will come back in 30 minutes to complete the assessment."
C) "This will only take me a minute. Try and hold your breath while I do this."
D) "When do you think you will be ready? You could die if I don't check this."
Answer: B
Explanation: A) The assessment will include the area around the incision.
B) Though the assessment may be delayed slightly, it is better to medicate the client and then return when the medication has had a chance to work.
C) The client should be coached to breathe normally during the assessment.
D) The nurse should not threaten the client to complete the assessment.
Page Ref: 621
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 14.7 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

24) The nurse is attending the birth of a premature neonate and prepares to do the 1-minute Apgar score of this infant. Assessment data shows the infant has a heart rate of 98, is not crying, has some flexion of the extremities, has a grimace when stimulated, and is very pale. Which will the nurse record as the Apgar score?
A) 6
B) 5
C) 4
D) 3
Answer: C
Explanation: A) The infant's score does not equal 6.
B) The infant's score does not equal 5.
C) The infant has a score of 4-1 for a heart rate less than 100, 0 for no cry, 1 for some flexion of the extremities, 1 for grimace, and 1 for color.
D) The baby's score is greater than 3.
Page Ref: 622
Cognitive Level: Applying
Client Need/Sub: Health Promotion and Maintenance
Standards: Nursing Process: Assessment | Learning Outcome: 14.8 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

Clinical Nursing Skills: A Concept-Based Approach, 4e (Pearson)
Chapter 15 Safety

1) The nurse is assessing an older adult client who has come to the emergency department with a possible urinary tract infection. Which would alert the nurse that this client has been abused?
A) The right knee has a large bruise.
B) The underwear smells of urine.
C) There are bilateral contusions above the elbows.
D) There are small lacerations on the forehead.
Answer: C
Explanation: A) A single knee bruise does not indicate abuse.
B) Underwear smelling of urine could be caused by incontinence.
C) Bilateral bruises or contusions may indicate passive restraining, which could be a sign of abuse.
D) Lacerations on the forehead do not indicate abuse.
Page Ref: 639
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 15.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

2) The nurse is completing an assessment of an older adult client whose primary caretaker is the grandson. Which would alert the nurse that this client is a possible victim of emotional abuse?
A) The client refuses to look at the grandson.
B) The client reprimands the grandson for being late to the appointment.
C) The client asks the grandson to leave the room during the pelvic examination.
D) The client tells the nurse that the grandson isn't a very good cook.
Answer: A
Explanation: A) Signs of emotional abuse include becoming quiet when the caregiver enters the room or refusing the answer if caregiver is present.
B) Reprimanding does not indicate emotional abuse.
C) The male child should leave the room while the client has a pelvic examination.
D) Stating the grandson is not a good cook does not indicate emotional abuse.
Page Ref: 639
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 15.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

3) Which statement by an older adult client to the nurse would indicate that the client is being abused? **Select all that apply.**
A) "I am so cold all of the time because I don't have any warm clothes."
B) "I think I have a sore on my bottom. No one ever cleans me after I use the bathroom."
C) "Please don't tell that lady that brought me here that I showed you my bruises."
D) "I wish I had someone else to bring me here. That lady is a terrible driver."
E) "The lady insists on using the cheap soap to wash my clothes. I hate the smell."
Answer: A, B, C
Explanation: A) This statement indicates that the client is being deprived of adequate clothing and is a possible sign of abuse.
B) This statement indicates that the client is receiving inadequate personal care and is a possible sign of abuse.
C) This statement indicates that the client is afraid of the caregiver and is a sign of abuse.
D) Reporting an issue with transportation does not indicate abuse.
E) An issue with laundry detergent does not indicate abuse.
Page Ref: 639
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 15.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

4) The nurse has completed an assessment of an older adult client who lives with her son and his wife. The nurse observed some bruising on the client but no other signs of abuse. Which question by the nurse to the client would be most helpful in determining if abuse is occurring?

A) "Who manages your money?"
B) "How did the bruises I noted on your wrists occur?"
C) "Are you happy with where you live?"
D) "How often do you see the doctor?"
Answer: B
Explanation: A) Asking about money management would not be associated with the bruises.
B) The nurse should find out how the suspected abusive bruises were obtained. This would be the most helpful question in this situation.
C) Asking if the client is happy does not help determine the reason for the bruises.
D) Frequency of doctor visits does not help determine the reason for the bruises.
Page Ref: 639
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 15.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

5) The nurse is caring for four clients and knows that which client is at the highest risk for falls?
A) An older adult client who is 2 days postoperative from a hip replacement, uses a walker to ambulate, and requires pain medication every 6 hours
B) An older adult client who had a coronary artery stent placed three days ago
C) An older adult client who is preparing for discharge and requires continued antibiotics
D) An older adult client who was admitted yesterday for dehydration and is confused and sometimes combative
Answer: D
Explanation: A) The client who uses a walker to ambulate is not at the highest risk for a fall.
B) A client recovering from stent placement is not at the highest risk for a fall.
C) A client being discharged on antibiotics is not at risk for a fall.
D) This client was just admitted for dehydration and shows acute changes in cognition with signs of delirium. This client is at the highest risk for falling.
Page Ref: 640
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 15.2 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

6) The nurse has just placed a bed alarm for a client who is disoriented and has explained its use to the client and his family. Which statement by a family member indicates a need for further information related to fall prevention?
A) "I know this bed alarm will help everyone know if my father tries to get out of bed without help."
B) "I wish this bed alarm would keep my father in bed."
C) "Now that this bed alarm has been installed on my dad's bed, I can go home and get a good night's sleep."
D) "It is so hard watching my father be so confused. I guess this bed alarm is better than nothing."
Answer: C
Explanation: A) The bed alarm will alert if the client is attempting to get out of bed.
B) The bed alarm is not a restraint.
C) While the bed alarm lets everyone know if the client attempts to get out of bed, it doesn't negate the need for someone to be with a confused client.
D) The bed alarm is a safety device.
Page Ref: 641
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 15.2 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

7) The nurse is caring for a client who recently began taking prescribed blood pressure medicine. Which teaching will be most important to this client in the prevention of falls?
A) Wear slipper or non-skid socks when walking.
B) Make sure that the lighting is good when you get out of bed.
C) Use the handrails next to the toilet when getting on and off the toilet.
D) Sit on the side of the bed for at least a minute before getting out of bed.
Answer: D
Explanation: A) Slippers or non-skid socks will not help if the client becomes dizzy from blood pressure medication.
B) Lighting will not help if the client becomes dizzy from blood pressure medication.
C) Using handrails when getting off the toilet will not help if the client becomes dizzy from blood pressure medication.
D) Blood pressure medicine may cause postural hypotension, so the client should be taught to sit on the side of the bed for a minute or two until the possibility of dizziness is over before getting out of bed.
Page Ref: 641
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 15.2 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

8) While admitting an adult client for treatment of pneumonia, the nurse discovers that the client has been diagnosed with a seizure disorder. What safety precautions will the nurse put into place for this client? **Select all that apply.**
A) Request that the client wear a helmet while out of bed.
B) Place suction equipment in the room.
C) Instruct the client to remain in bed at all times.
D) Place the client in a room at the end of the unit to reduce stimuli.
E) Pad the side rails and head board of the bed with blankets.
Answer: B, E
Explanation: A) A helmet may be used for a pediatric client.
B) Suction equipment should be in place to prevent aspiration of secretions during a seizure.
C) The client does not need to remain in bed at all times.
D) The client should not be placed in a room further away from the nurses' station.
E) The bed (headboard, side rails) should be padded to prevent injury in the event the client has a seizure.
Page Ref: 642
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 15.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

9) The nurse is assisting a client to the bathroom when the client begins to have a tonic-clonic seizure. Which is the first thing that the nurse should do at this time?
A) Assist the client back to bed.
B) Take the client's vital signs.
C) Time the seizure.
D) Remove the client's clothing.
Answer: C
Explanation: A) The client should not be taken back to bed during the seizure.
B) Vital signs can be assessed after the seizure.
C) It is important for the nurse to time the seizure duration because it is impossible to know exactly how long the seizure lasts without timing it.
D) The client's clothing is not removed however it should be loosened around the client's neck.
Page Ref: 643
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 15.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

10) The nurse has been caring for a client who had a tonic-clonic seizure in the hallway of the nursing unit. Which is the first action the nurse should do when the seizure has finished?
A) Reassure the client that a seizure has occurred and that the nurse is providing care.
B) Assist the client to the bathroom to void.
C) Ask the client to report the last memory prior to the seizure.
D) Provide clear liquids to soothe a dry mouth.
Answer: A
Explanation: A) After a seizure is over, the client is often confused and needs to be reassured about the present situation.
B) The client should not be moved until stable.
C) The client's memory can be assessed later.
D) The client should not be given fluids until a gag reflex is assessed.
Page Ref: 643
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 15.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

11) The nurse is discussing safety precautions at home with the parents of an 8-year-old child diagnosed with a seizure disorder. Which play activity would the nurse recommend to this family?
A) Sitting quietly reading a book
B) Swimming at the beach
C) Riding a bicycle
D) Participating on a robotic team
Answer: D
Explanation: A) The client does not need to read books instead of participating in play.
B) Swimming may be too dangerous for a child with a seizure disorder.
C) Riding a bicycle would be too dangerous for a child with a seizure disorder.
D) Joining a robotics team would allow the child to be engaged in play without needing direct supervision and the other team members could intervene if a seizure occurred while involved in this activity.
Page Ref: 644
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 15.3 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

12) The nurse is developing a safety plan for an older adult client who has just been admitted to the nursing unit. The client has limited hearing and eyesight. His medications include furosemide (Lasix) and a baby aspirin. He still lives alone in his home and is able to do small household chores but his daughter comes over every week to take him grocery shopping. Which information will have an impact on the development of the safety plan? **Select all that apply.**
A) The client takes furosemide.
B) The client takes aspirin.
C) The client has limited hearing and eyesight.
D) The client lives alone.
E) The client's daughter takes him grocery shopping.
Answer: A, C, D
Explanation: A) Furosemide is a diuretic and makes the client produce more urine, which means the client would need to urinate more. This should be included in the safety plan.
B) The small dose of aspirin is not a safety hazard.
C) The client's limited hearing and eyesight must be a part of the safety plan because it affects the client's ability to know of an emergency.
D) The client's living arrangements are a large part of the emergency plan because the nurse must develop ways for the client to contact emergency assistance or to know if an emergency is taking place.
E) The client has assistance with grocery shopping, so this is not a safety hazard.
Page Ref: 646
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 15.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

13) The home health nurse visits an older adult client's home prior to a client's discharge from the hospital to evaluate the home for any safety issues. Which situation if seen by the nurse would constitute the largest safety issue for this client?
A) A trapeze lift has been placed above the client's bed to assist with getting out of bed.
B) The house has one bathroom with a traditional bathtub.
C) Skid-proof strips have been placed on the area rugs in the house.
D) Most of the houseplants appear to have dying foliage.
Answer: B
Explanation: A) A trapeze would be helpful.
B) The client is elderly and the client will need to step into and out of a bathtub, which puts the client at high risk for falling.
C) Skid-proof strips would be helpful.
D) The condition of the house plants are not a safety hazard.
Page Ref: 647
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 15.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

14) The nurse is caring for a client who is disoriented and confused. Which is the safest and least restrictive way to assist this client?
A) Place a wrist restraint on the right arm only.

B) Dim the lights and keep the room as quiet as possible.
C) Put the call light on the client's bed but remove everything else from the client's line of vision.
D) Turn off the lights but turn on the television so the client thinks someone is in the room.
Answer: B
Explanation: A) Wrist restraints should not be used.
B) Confused clients often respond well to a decrease in both auditory and visual stimuli, so dimming and lights and keeping the room quiet will help keep the client safe.
C) Items should be placed in the client's line of vision.
D) The television should not be left on as this would provide too much stimulation.
Page Ref: 647
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 15.4 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

15) The nurse is caring for a female client who has just completed taking a shower. The nurse notes that she is using her own hair dryer to dry her hair. Which is the nurse's BEST statement to the client concerning this possible safety issue?
A) "I noticed you are using your own hair dryer. We don't allow that."
B) "Before you start drying your hair, let me see if our maintenance department can come up and check it for safety."
C) "We usually don't allow clients to use their own electrical products from home but if I don't see you use it, then I don't know you have it."
D) "Your hair looks good just the way it is. Please put the hair dryer away for today."
Answer: B
Explanation: A) The hair dryer can be used however needs to be checked for safety.
B) The policy in most facilities is to have the maintenance department check home electrical appliances for safety before they are used in that facility.
C) The nurse should not pretend that the client does not have a hair dryer.
D) The client wants to dry the hair and should have the device checked before using it.
Page Ref: 650
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 15.5 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

16) The nurse smells smoke and notes what appears to be a fire in the waste basket in the client's room. Which is the nurse's first action when the fire is noted?

A) Pull the fire alarm.
B) Grab the closest fire extinguisher.
C) Enter the client's room and immediately close the client's door.
D) Assist the client out of the room.
Answer: D
Explanation: A) The fire alarm is not pulled first.
B) The fire extinguisher is not located first.
C) The client needs to be removed from the room.
D) The nurse must first rescue and remove all clients in immediate danger.
Page Ref: 649
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 15.6 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

17) The nurse notices a fire at the end of the hall of a second-floor unit and recognizes that the clients will need to be evacuated out of the hospital. The nurse will use which carrying method to evacuate clients safely out of the hospital?
A) Blanket method
B) Cradle method
C) Back-strap method
D) Two-person swing method
Answer: C
Explanation: A) The blanket method would not be a technique to safely remove a client out of the hospital.
B) The cradle method would not be a a technique to safely remove a client out of the hospital.
C) The back-strap method allows the nurse to carry the client and navigate the stairs for evacuation.
D) The two-person swing method would not be a technique to evacuate clients safely out of the hospital.
Page Ref: 649
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 15.6 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

18) The nurse is caring for a client who occasionally becomes confused. When the client has a period of confusion, he attempts to pull out his indwelling urinary catheter. When the client is oriented, he likes to do crossword puzzles. After receiving an order for restraints, which would be the BEST place(s) to place the restraint in this client?
A) Around the client's elbows
B) Around the client's wrists
C) Around the client's fingers (using a mitt restraint)
D) Around the client's torso (using a vest-type restraint)
Answer: A
Explanation: A) Wrist restraints may be placed on the wrist or elbow. If placed on the elbow, it will prevent the client from grabbing the catheter during confusion but allow the client to do his crossword puzzle.
B) Restraints around the wrists will stop the client from completing puzzles.
C) The client does not need mitt restraints.
D) The vest restraint would not stop the client from attempting to pull out the urinary catheter.
Page Ref: 658
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 15.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

19) The nurse is caring for an older adult client who is very confused and is also very thin. The healthcare provider has prescribed wrist restraints to help prevent the client from getting out of bed. Which is the priority for the nurse in applying the wrist restraints to this client?
A) The restraints must be applied loosely to prevent the client from rubbing the skin against the restraint.
B) The nurse must pad the client's wrist bones before applying the wrist restraint.
C) The restraints should be tied to the bed rails to give the nurse easy access to allow quick removal of the restraints if necessary.
D) The nurse should use a vest restraint instead of a wrist restraint to prevent injuring the client's skin.
Answer: B
Explanation: A) The restraints should not be applied loosely.
B) The nurse must pad the bony prominences to prevent skin breakdown from the restraints.
C) Restraints are not tied to the bed rails.
D) A vest restraint would not prevent the client from attempting to get out of bed.
Page Ref: 657
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 15.7 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

20) The nurse must restrain a child and knows that a mummy immobilizer restraint will be best for which child in the nurse's care?
A) A 7-year-old child who has a laceration of the forearm
B) A 5-year-old child who needs to have an IV started in the antecubital space
C) A 3-year-old child who has a laceration of the forehead that needs stitches
D) A 1-year-old child who needs a lumbar puncture to check for meningitis
Answer: C
Explanation: A) A 7-year-old child does not need a mummy immobilizer.
B) A mummy immobilizer would not be appropriate for a child who needs an intravenous line inserted.
C) The mummy immobilizer would prevent the child from moving while treating the forehead laceration.
D) A mummy immobilizer will not expose the spine for the lumbar puncture.
Page Ref: 651
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Intervention | Learning Outcome: 15.8 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

Clinical Nursing Skills: A Concept-Based Approach, 4e (Pearson)
Chapter 16 Tissue Integrity

1) The nurse is preparing to change a dry dressing of a surgical wound and will use which technique to ensure that the wound stays clean during the procedure?
A) The nurse will wear a gown, cap, and shoe covers and will use sterile gloves for the procedure.
B) The nurse will wear a mask and use clean gloves to remove the outer dressing.
C) The nurse does not need to wear any personal protective equipment (PPE) during the procedure.
D) The nurse does not need to wear clean gloves to clean the wound and but should use sterile gloves to reapply the dressing.
Answer: B
Explanation: A) A gown, cap, and show covers do not need to be worn.
B) A mask should be worn during the procedure to prevent contamination of the wound by droplet spray from the nurse's respiratory tract.
C) PPE is needed for the procedure.
D) Sterile gloves are not needed to remove the dressing. Sterile gloves are needed to clean the wound and change the dressing.
Page Ref: 338
Cognitive Level: Understanding
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 16.1 | QSEN Competencies: Safety

AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

2) The nurse is observing a second nurse who is changing a dressing. While observing the procedure, which would cause the nurse to stop the second nurse and take over the procedure?
A) The second nurse used one swab to clean the wound.
B) The second nurse cleaned the wound from near the wound and then outward.
C) The second nurse kept the forceps tip lower than the forceps handle when cleaning the wound.
D) The second nurse put on clean gloves to begin the wound cleaning process.
Answer: A
Explanation: A) A separate swab should be used for each stroke during cleaning.
B) The wound is cleaned from the center to the periphery.
C) The forceps tip should be lower than the handle.
D) Clean gloves can be worn to clean the wound.
Page Ref: 668
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 16.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

3) The nurse is preparing to change the dressing and clean the wound of a client who had hip replacement surgery one day ago. The nurse plans to use which solution for the most effective cleaning of the wound?
A) Sterile water
B) Hydrogen peroxide
C) Povidone-iodine
D) Normal saline
Answer: D
Explanation: A) Wounds are not typically cleaned with sterile water.
B) Hydrogen peroxide would need to be diluted before using.
C) Povidone-iodine is not used to clean a wound.
D) Normal saline is the most widely used solution for cleaning and irrigating an acute wound because it does not disrupt the physiology of the wound bed.
Page Ref: 669
Cognitive Level: Remembering
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 16.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

4) While making rounds, the charge nurse observes a staff nurse cleaning a surgical wound and notes that the staff nurse has cleaned the wound from the top to the bottom of the wound. Which action should the charge nurse take in this situation?

A) Request the staff nurse clean the wound again using a circular motion and cleaning from outside the wound to the wound itself.
B) Make arrangements for the staff nurse to visit the education department for retraining in wound cleaning.
C) Continue with rounds with the knowledge that the staff nurse used the proper cleaning technique.
D) Inform the staff nurse that the charge nurse will be observing the client for signs of infection.
Answer: C
Explanation: A) The wound should not be cleaned in a circular motion. The wound should not be cleaned from the outside to the inside.
B) The nurse does not need retraining.
C) The staff nurse used proper wound cleaning technique so the charge nurse should continue with rounds.
D) The wound was cleaned correctly and does not need to be observed for signs of infection.
Page Ref: 669
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 16.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

5) Place the steps for changing a sterile surgical dressing in the appropriate order.
A) Apply clean gloves and remove the old dressing.
B) Apply sterile gloves.
C) Create a sterile field.
D) Assess the incision area for erythema, edema, or drainage.
E) Replace sterile dressing.
F) Clean the incision using sterile saline.
Answer: C, A, D, B, F, E
Explanation: A) The old dressing is removed after the sterile field is prepared.
B) Sterile gloves are put on after the old dressing is removed and the incision is assessed.
C) The sterile field is the first thing that is completed.
D) The incision is assessed after the old dressing is removed and before sterile gloves are placed for cleaning the incision.
E) The sterile dressing is replaced as the last step.
F) The incision is cleaned with sterile saline after sterile gloves are put on.
Page Ref: 671
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 16.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

6) The nurse is preparing to change the dressing of a client who had abdominal surgery 3 days ago. The nurse notes that the incision has purulent drainage and appears very puffy. The client states that the pain level has increased from a 3 to a 7 in the last 24 hours. Which action should the nurse take in regard to this client's wound?

A) Clean the wound, place a new dressing, and plan to recheck the incision in 4 hours.
B) Contact the client's surgeon after obtaining the client's vital signs.
C) Recognize that this is an expected outcome for a client on the third day after surgery.
D) Culture the wound drainage and redress the wound.
Answer: B
Explanation: A) The wound needs to be assessed by the surgeon immediately and not in 4 hours.
B) The nurse should obtain the client's vital signs to see if there are signs of systemic infection and then the surgeon should be notified with all of the information.
C) This is not an expected outcome on the third day after surgery.
D) The surgeon will determine if the wound needs to be cultured.
Page Ref: 662, 683
Cognitive Level: Analyzing
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 16.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

7) The home health nurse is making the first visit to a client who will continue to need sterile dressing changes after abdominal surgery. In assessing the home environment, which must be considered when performing the home dressing change?
A) There is dust on many of the surfaces.
B) The furniture appears worn.
C) There is a cat that is allowed on the furniture.
D) There are dirty dishes on the dining room table.
Answer: C
Explanation: A) Dust will not interfere with the dressing change.
B) The appearance of the furniture is not of concern.
C) The nurse will need to make sure that the cat is kept out of the room where the dressing change is to be performed.
D) Dirty dishes are not of concern for the dressing change.
Page Ref: 683
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Assessment | Learning Outcome: 16.1 | QSEN Competencies: Safety
AACN Domains and Comps.: 5.2 Contribute to a culture of patient safety.
NLN Competencies: Quality & Safety

8) The healthcare provider has ordered an elastic bandage to be applied to a wound on a client's femur. The nurse will begin to apply the bandage at which point on the client's leg?
A) The groin
B) The wound itself
C) The knee
D) The hip
Answer: C
Explanation: A) The bandage will not be wrapped beginning at the groin.
B) The bandage will not be wrapped beginning at the actual wound.
C) The knee is the most distal point from the femur wound, so this is where the nurse will begin wrapping the elastic bandage.
D) The bandage will not be wrapped beginning at the hip.
Page Ref: 679
Cognitive Level: Understanding
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Implementation | Learning Outcome: 16.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

9) The nurse is caring for four clients who have had surgery and knows that which client would benefit the most from the application of a spiral elastic bandage?

A) The client who had a breast reduction.
B) The client who had a hip replacement.
C) The client who had ankle surgery.
D) The client who had a shoulder replacement.

Answer: C

Explanation: A) A spiral dressing would not be applicable for the client recovering from breast reduction.

B) A spiral dressing would not be applicable for the client recovering from hip replacement surgery.

C) A spiral elastic bandage would be appropriate for a client with ankle surgery if prescribed by the healthcare provider because it can be applied in a spiral fashion. It will also help reduce the swelling after the surgery and hold the dressing in place.

D) A spiral dressing would not be applicable for the client recovering from a shoulder replacement.

Page Ref: 679
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Assessment | Learning Outcome: 16.2 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

10) The nurse is caring for a client with a large venous injury that has just begun to show signs of healing. The nurse contacts the healthcare provider and asks for a change from the chemical method of debridement for which reason?
A) Chemical debridement may damage the tissue that has just begun to heal.
B) Chemical debridement is more painful to venous injuries that have begun to show signs of healing.
C) Chemical debridement is ineffective for venous injuries that have just begun to show signs of healing.
D) Chemical debridement is more useful with arterial injuries than venous injuries.
Answer: A
Explanation: A) Chemical debridement causes viable tissue to be removed with necrotic tissue and may injure the new tissue in the venous injury.
B) Chemical debridement is not changed because it is more painful to venous injuries that are healing.
C) Chemical debridement is not changed because it is ineffective for venous injures that are healing.
D) Chemical debridement can be used for all types of wounds.
Page Ref: 674
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 16.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.5 Develop a plan of care.
NLN Competencies: Knowledge and Science

11) The nurse has applied an occlusive dressing to a stage 1 pressure injury and knows that this type of dressing assists in debridement of the wound in which way?
A) It mechanically debrides the wound.
B) Enzymes are applied to the wound to remove necrotic tissue.
C) The dressing maintains a moist environment that uses the body's own enzymes.
D) The dressing dries the injury environment, which encourages sloughing of the injured tissue.
Answer: C
Explanation: A) A wet-to-dry dressing mechanically debrides the wound.
B) Chemical enzymes are used to remove necrotic tissue.
C) An occlusive dressing uses autolytic debridement by using the body's own enzymes and moisture to rehydrate, moisten, and slough tissue.
D) A dry dressing dries the environment to encourage sloughing of the injured tissue.
Page Ref: 674
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 16.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

12) The nurse is caring for a client who sustained second-degree burns to both feet. The healthcare provider has ordered debridement of necrotic tissue by mechanical means. The nurse will use which debridement technique that would be the BEST method to complete this task?
A) Wet-to dry dressing changes
B) Hydrotherapy
C) Application of enzymes
D) Application of an occlusive dressing
Answer: B
Explanation: A) Wet-to-dry dressings would take too long to debride the injured area.
B) Hydrotherapy involves placing a body part or parts, in this case feet, into a tub of water that pulses and agitates to mechanically debride a large area of tissue at one time.
C) Enzymes use chemicals to debride the area.
D) An occlusive dressing is autolytic which uses the body's own enzymes and moisture to rehydrate, moisten, and slough tissue.
Page Ref: 674
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 16.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

13) The nurse is using wet-to-dry dressing changes to assist in debridement of an open abdominal wound and knows that which step must be performed to ensure that the newly granulated tissue in the wound will not be injured during the dressing changes?

A) Place a heat lamp over the dressing for 15 minutes after the dressing change to prevent chilling the client with the cool dressings.
B) Rewet the dressings with normal saline every 15 minutes to ensure adequate debridement.
C) Soak the dressing with normal saline prior to removal of the packed gauze to prevent damage to the granulating tissue.
D) Premedicate the client 1 hour before the dressing change to improve client cooperation during the dressing change.
Answer: C
Explanation: A) A heat lamp will dry the dressing.
B) The dressings are not rewetted every 15 minutes because this does not permit the dressing to dry.
C) Soaking the dressing with normal saline prior to removing the gauze prevents injury to the newly granulated tissue.
D) Premedicating the client prior to the dressing change is to reduce pain and has nothing to do with protecting the granulation tissue.
Page Ref: 678
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 16.3 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

14) The nurse is completing a skin assessment at the beginning of the shift and will pay particular attention to which areas of the body that are most prone to skin breakdown? **Select all that apply.**

A) Knees
B) Heels
C) Shoulders
D) Sacrum
E) Toes

Answer: B, D

Explanation: A) The knees are not most prone to skin breakdown.

B) The heels are an area of the body that commonly have skin breakdown because they are at the back of the foot and the weight of the foot rests against the bed.

C) The shoulders are not most prone to skin breakdown.

D) The sacrum is an area of the body that often sees breakdown because there is little fat between the skin and the sacrum, there is high moisture, and it takes the full weight of the body.

E) The toes are not most prone to skin breakdown.

Page Ref: 695

Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential

Standards: Nursing Process: Assessment | Learning Outcome: 16.4 | QSEN Competencies: Patient-Centered Care

AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.

NLN Competencies: Knowledge and Science

15) The nurse has completed the Braden Risk Assessment Scale on a client who has been diagnosed with a pelvic fracture and has not been able to get out of bed for the last 6 days. This morning the client's score is 10, so the nurse will institute which measures that will help prevent further skin injury? **Select all that apply.**
A) Bathe the client every day.
B) Use tepid water when bathing the client.
C) Position the client to allow the heels to hang over the bed.
D) Elevate the client's head 45 degrees.
E) Increase the humidity in the client's room.
Answer: B, C, E
Explanation: A) Daily baths are not essential.
B) Tepid water prevents injury to the skin.
C) The heels should be raised off the bed by placing pillows under the legs or allow the heels to hang over the edge of the bed.
D) The head of the bed should not be at 45 degrees as this will encourage shearing over the sacrum.
E) Provide humidity to prevent drying of the skin.
Page Ref: 697
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 16.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

16) The nurse is caring for an older adult client who was admitted to the hospital after having a stroke. The client was in extremely critical condition on admission to the emergency department and a Braden Risk Assessment Scale was not completed. On the client's fifth day of hospitalization, the nurse notes that the client has developed a stage one pressure injury on the elbow of the side affected by the stroke. Which is the implication of this situation in relation to reimbursement for care of the pressure injury?
A) Medicare will pay for the treatment because it was noticed while the client was still hospitalized.
B) Medicare will not pay for treatment because the pressure injury was not properly documented.
C) Medicare will pay for the treatment because pressure injuries are an expected outcome in a client who has had a stroke.
D) Medicare will not pay for treatment because an initial skin assessment was not completed, so it is assumed that the pressure injury was caused by improper care at the hospital.
Answer: D
Explanation: A) Medicare will not pay for the treatment because it was noticed while the client was hospitalized.
B) The documentation of the pressure injury is not the reason why Medicare will not pay for the care.
C) Pressure injures are not an expected outcome in a client who has had a stroke.
D) Even though the client fell when the stroke occurred, which may have caused redness or even a breakdown of the client's elbow, the lack of an admission skin assessment means that Medicare will assume that the injury was caused by lack of proper skin care during the hospitalization.
Page Ref: 697
Cognitive Level: Analyzing

Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 16.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

17) The nurse is caring for a client who is at high risk for pressure injury formation because of which factors? **Select all that apply.**
A) The client is often incontinent of urine.
B) The client uses a wheelchair occasionally.
C) The client is vegan.
D) The client has severe arthritis and has trouble being placed in a lateral position.
E) The client attempts to change position every 15 minutes when sitting in a chair.
Answer: A, C, D
Explanation: A) Moisture of the skin from sweat or urine increases the chance for pressure injury formation.
B) Occasional use of a wheelchair does not increase the risk for pressure injury development.
C) Lack of adequate protein is associated with pressure injury formation. Being a vegan means that sources of protein may not be available to the client.
D) The client's arthritis limits the client's ability to move and increases the chance for pressure injury formation.
E) Moving positions every 15 minutes when seated will reduce the risk for pressure injury development.
Page Ref: 698
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Assessment | Learning Outcome: 16.4 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

18) The nurse is caring for 4 clients with wounds and would ask that which client should be evaluated further for negative-pressure wound therapy?
A) The client with a burned right arm that requires hydrotherapy three times a day for dressing changes.
B) The client with a wound on the foot that is located near the toes.
C) The client with a wound on the forearm who is malnourished due to anorexia from chemotherapy.
D) The client with an abdominal incision that has not healed and is restricted to bed.
Answer: D
Explanation: A) The client with a burn is receiving hydrotherapy 3 times a day.
B) A wound near the toes would be challenging to apply the negative-pressure wound device.
C) The client who is malnourished is not nutritionally stable for the negative-pressure wound device.
D) A client with an abdominal wound and who is in bed would be able to use the wound vac 22 hours/day.
Page Ref: 693
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Basic Care and Comfort
Standards: Nursing Process: Assessment | Learning Outcome: 16.5 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.3 Integrate assessment skills in practice.
NLN Competencies: Knowledge and Science

19) The wound care nurse has been asked by the healthcare provider to begin negative-pressure wound therapy on a client. Upon assessment of the wound, the nurse notes that the wound still requires a great deal of debridement. Which should the nurse do in this situation?
A) Apply the wound vac because this is the intent of the therapy.
B) Contact the healthcare provider and arrange for debridement of the wound.
C) Apply an autolytic dressing for 24 hours and then apply the wound vac.
D) Place enzymatic debridement product under the black foam and begin the negative-pressure wound therapy.
Answer: B
Explanation: A) The wound needs to be debrided before applying the wound vac.
B) If debridement is required before the wound vac can be applied, the nurse should notify the appropriate person, in this case the healthcare provider who can arrange for the debridement to take place.
C) An autolytic may not be appropriate to debride the wound.
D) A debridement product is not used under the wound vac.
Page Ref: 693
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 16.5 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

20) A client is slated to begin negative-pressure wound therapy tomorrow and the nurse is reinforcing the teaching about this therapy. Which statement by the client requires further teaching by the nurse?
A) "I realize that this device will be hooked up to me almost all day and night."
B) "I believe most people have to use this therapy for about 10 days."
C) "I need to make sure that I continue to eat three balanced meals a day to help my wound heal."
D) "I realize that there will be some pain associated with this therapy but I want my wound to heal."
Answer: B
Explanation: A) The device is used for 22 to 24 hours a day.
B) This statement needs further teaching because most clients required 4 to 6 weeks of treatment.
C) The client needs to maintain nutritional status.
D) The dressing might be uncomfortable.
Page Ref: 693
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Physiological Adaptation
Standards: Nursing Process: Evaluation | Learning Outcome: 16.5 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.7 Evaluate outcomes of care.
NLN Competencies: Knowledge and Science

21) The nurse is caring for a client who is receiving negative-pressure wound therapy for an infected leg wound and is aware that the dressing on this wound must be changed how often?
A) Once a week
B) Every 48 hours
C) Every 24 hours
D) Every 4 hours
Answer: C
Explanation: A) The dressing needs to be changed more frequently than once a week.
B) An uninfected wound is changed every 48 hours.
C) An infected wound dressing change must be performed every 12 to 24 hours.
D) The dressing does not need to be changed every 4 hours.
Page Ref: 694
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Planning | Learning Outcome: 16.5 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.5 Develop a plan of care.
NLN Competencies: Knowledge and Science

22) The nurse is preparing to remove staples from a woman who had a cesarean section 6 days ago and will use which forms of personal protective equipment when performing this task?
A) Sterile gloves, face shield
B) Face shield, gown, clean gloves
C) Gown, sterile gloves, shoe covers
D) Clean gloves
Answer: D
Explanation: A) Sterile gloves and a face shield are not needed to remove staples.
B) A face shield and gown are not needed to remove staples.
C) A gown, sterile gloves, and shoe covers are not needed to remove staples.
D) Clean gloves are all that is needed to remove staples.
Page Ref: 699
Cognitive Level: Applying
Client Need/Sub: Safe and Effective Care Environment: Safety and Infection Control
Standards: Nursing Process: Implementation | Learning Outcome: 16.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

23) The nurse is preparing to remove sutures from a client who sustained a long, deep laceration after a motor vehicle accident and will use what technique to maintain wound stability?
A) The nurse will remove every other suture and reassess the wound for any gaping areas.
B) The nurse will remove all the sutures while holding the edges of the wound together.
C) The nurse will remove the top half of the sutures and return in 1 hour and remove the remaining sutures.
D) The nurse will remove all of the sutures and immediately place a tight dressing over the laceration to ensure that the wound edges stay together.
Answer: A
Explanation: A) To prevent wound dehiscence, the nurse should remove every other suture and then reassess the wound to ensure that the remainder of the sutures can be safely removed.
B) All of the sutures should not be removed at once.
C) The top half of the sutures are not removed before the bottom half.
D) All of the sutures are not removed followed by holding the wound edges together with a tight dressing.
Page Ref: 699
Cognitive Level: Applying
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Implementation | Learning Outcome: 16.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.6 Demonstrate accountability for care delivery.
NLN Competencies: Knowledge and Science

24) The nurse has just removed sutures on a client and has completed teaching the client about care of the wound at home. Which statement by the client indicates that the client understands the instructions given?
A) "I will leave the dressing in place until I see my doctor in four weeks."
B) "I will only eat soft foods and avoid red meat until my wound is completely healed."
C) "I plan to take a shower every day but not let any soap touch my wound."
D) "I plan to use moisturizing lotion on my wound daily to soften and prevent ugly scar formation."
Answer: C
Explanation: A) The dressing should be changed daily.
B) The client needs to maintain a nutritionally sound diet.
C) The client should shower every day but not put soap on the wound.
D) Lotions should not be applied over the wound.
Page Ref: 698
Cognitive Level: Analyzing
Client Need/Sub: Physiological Integrity: Reduction of Risk Potential
Standards: Nursing Process: Evaluation | Learning Outcome: 16.6 | QSEN Competencies: Patient-Centered Care
AACN Domains and Comps.: 2.7 Evaluate outcomes of care.
NLN Competencies: Knowledge and Science